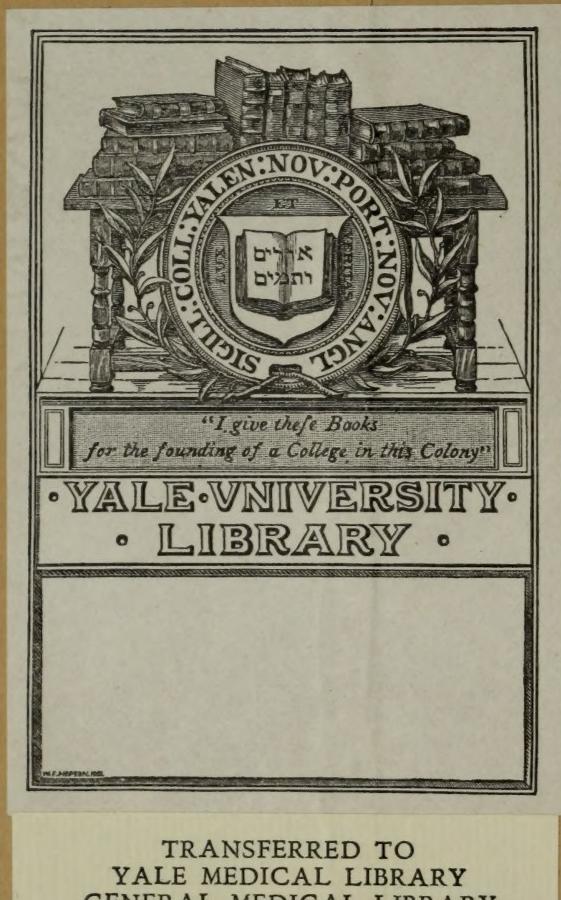




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# MARYLAND MEDICAL JOURNAL

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## ORIGINAL ARTICLES.

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### EXTRACTS FROM AN INTRODUCTORY ADDRESS.

DELIVERED AT THE COLLEGE OF PHYSICIANS AND SURGEONS OF BALTIMORE, SEPTEMBER 30, 1895.

*By Thomas Opie, M. D.,*

Professor of Gynecology, College of Physicians and Surgeons.

MEDICAL schools have been groping along for 2000 years. I do not mean to be ungrateful and to throw stones at our predecessors who have given us the substratum and foundations on which our fabric rests, but I will assert that the last twenty-five years constitutes a new era in the medical world. The useful facts, the honest hard work of students and teachers, has increased in an arithmetical progression.

The medical schools of today have a heavy responsibility resting upon them. Many of them have been and are now working upon a worthy and commendable plane. There are still, however, laggards in the vineyard, perhaps some with whom "the jingling of the guinea helps the hurt which honor feels." At all events it belongs to history that boards of health were deemed a necessity, originally to perform duties such as to limit contagion, circumscribe and abolish filth; indeed, their duties were very much those of the quarantine officer of a port. Through medical dictation later on, laws were enacted for the further protection of the State, against doctors who, devoid of proper preliminary training and education, were dumped on its citizens. In most of the States now the examination of the gradu-

uates before registration is made by a special medical board of examiners.

Aside from this compulsory reformation, there is a strong indwelling honor in the large majority of medical schools, a tone, pride, laudable ambition, which keeps them in straight and safe paths.

Medical schools can no more afford to be engaged in the sewers of politics than can the individual doctor. It is seldom, I am pleased to be able to say, that you find anyone of them doing so. I recall in the early history of boards of examiners, a school in one of our sister States which distinguished itself as a political boss. It secured for itself and the other medical schools of the same State the passage of a law through their legislature, making their respective faculties a corps of State medical examiners. Some of these schools thus signalized were made unhappy by sharing the bitter fruit of this unhallowed game. The law was in the hands of parties inspired in great measure by self-interested motives. The graduate who had the hardihood to go outside his State for a medical education was given a searching examination and made to pay a heavy fee for his rasping, while those who graduated inside the limits of this State paid a nominal fee and were registered with-

out examination. The citizens of this sovereign State, however, were not slow to see that they were not as free in the exercise of their rights as those of other States; that they had been robbed of the privilege of determining upon where they would secure a medical education for their sons.

The law was expunged and a non-partisan and impartial board comprised of disinterested physicians outside the medical schools was organized and has done pure and good work ever since.

There has been some breaking faith and dodging lately near akin to politics, in a circle which is regarded as the highest medical tribunal in our land.

It is time to break the solemn silence, which hangs like a pall of mourning over our noble and ethical profession.

We are today witnessing an attempt to thwart the battle for reform in medical teaching, a violation of mutual pledges, an arrest of that elevation of the standard for the new doctor which the general profession and the general public unite in demanding of the medical schools and which the schools themselves had already adopted.

In 1894 a meeting was held of the National Medical College Association at San Francisco. At this far off meeting on the Pacific coast, there was a slim representation of the Eastern schools. It was decided by this meeting to adopt a four years' curriculum. In May of 1895 a meeting was held in this city. The five schools of Baltimore, all in full membership, gave notice six months in advance of this meeting, as the law of the Association required, that they would protest against this hasty and, as we then believed, ill advised legislation of the San Francisco meeting. Accordingly, at the Baltimore meeting, the College of Physicians and Surgeons, the Maryland University, the Woman's Medical College, the Baltimore Medical College, and the Baltimore University School of Medicine having previously signed an agreement to do so, offered an amendment to postpone the adoption of the four years' course, five years. In other words, that instead of graduation on a four years' course terminating in

1899, it should be one terminating in 1904.

The Baltimore schools thought that it was an injudicious move because the three years' graded course had been in operation but one year and many of the schools were not as yet well established on that basis. Suffice it to say, we were beaten fairly and by a large majority in the vote and all seemed to be reconciled afterwards to the inevitable four years' curriculum, beginning with the session of 1895 and 1896, this session.

But the artful dodger turned up, the doctor of mercantile accomplishments; who thought that he could escape the issue, that if morally bound, he could not be held legally. The news spread like pestilence, that in school circles there was a money making opportunity, dead sure, an enticing chance for wrongdoing, without the dread of punishment. The thickness of the cuticle and the delicacy of sensibility of men varies considerably. Catalogues show a wide range of fancy sketches and fairy tales, but for inimitable cheek and fabulous narrative the following clipping from the catalogue of one of the dodging schools is preëminent in wickedness. Says this catalogue: "As will appear from the following resolution, adopted by this college and by all members of the American Medical College Association, attendance upon four full courses of instruction will be required of all matriculates after the session of 1895-96."

Is this the truth? Not a faint shadow of truth is in it. No, it is the iniquitous deceit of Satanic invention. The National College Association has made no utterance of any kind since the meeting in Baltimore last April, which fact is well known to every college in the membership. The ruling was then and remains unchanged in any way, that the four years' course should begin with 1894-95, a reiteration of the decision rendered the year before, at the San Francisco meeting. The catalogue to which we refer illustrates vividly "what a godly outside sin hath."

One of the colleges claiming to be a member of the National Association

of Medical Colleges in good standing, despite the well known fact that four years had been adopted as the curriculum for all the members, came out with the announcement, without the consent or even knowledge of the governing body, that they had adopted a three years' course of study. This medical school has been writing industriously to students for the coming session that should they send in their matriculation fee (\$5) before October 1, 1895, they will be admitted to their three years' course. Their catalogue had already boldly announced far and wide that their session would be a three years' one, but that they were holding on, notwithstanding, to the Association, whose mandate required of all its members alike a four years' curriculum. In the meanwhile, a still-hunt to rope in the student was pushed with energy by letter writing, telling him to hurry up! send in his matriculation fee before October 1, saying that after that, four years would be required.

This school's catalogue was its faculty's side of a contract and the time-saving, curriculum-shaving matriculation fee was the student's side of the binding contract. The mail of this enterprising institution was burdensome. There was a rush to get through this gap in the fence of the Association which was thought by its builders to have been perfectly secure.

In medical circles not long since a northwester was believed to be brewing. The heavens seemed angry and lowering as though a cloud-burst or the judgment day had come. On such a day, what a stir there is among the barn-yard fowls. The old hen only is self-poised and hurriedly gathers her chickens under her wings, moved by that imperious sentiment which throughout nature binds the offspring to its natal soil. Oh, sinner! think of it! Suppose that dark and doleful day had come on you before October 1, 1895, the day you had resolved to reform.

The face of the heavens has again become calm and forgiving, the Association has not as yet said a word of chiding, but the silence is ominous.

"Hasten, sinner, to be wise, stay not for the morrow's sun,  
Wisdom if thou still despise, harder 'tis to be won."

But how about those poor fellows who arrive after October 1? Will they have to take four years? It will be an awful solemn thing for them to have to take a four years' course, when so many have been admitted on the short gauge.

The Faculty of the College of Physicians and Surgeons has acquiesced loyally in the decision of the National Association of American Colleges. The Annual Catalogue was issued promptly, setting forth our position.

The Secretary of the Association of American Colleges wrote our Faculty July 23, expressing his pleasure at their frank and decisive statement as to the adoption of the four years' course and its definiteness as to the course of study laid down for the student of medicine.

This binding compact and mutual agreement between the schools has been grossly violated, as I have stated, by members, upon a mere quibble—a faulty wording of the law—knowing full well that according to the interpretation of the law, the requirement of four years was to be entered into by all the schools alike, not beginning October 1, as it has been misconstrued, but the law applied strictly to all students who entered upon the study of medicine during the session of 1895 and 1896, whether matriculated before the date October 1, or not.

It should be emphasized that the solemn agreement was thus violated for a mercantile advantage.

There is a prominent leader among the seceders who has attributes that are imputed to Hermes, the swift-footed messenger and ambassador for the gods and conductor of shades to Hades. He presided over the rearing and education of the young. He was noted for his versatility, sagacity and cunning. He was regarded as the god who gave increase to flocks and herds and on this account he was worshiped with special veneration by herdsmen. In his times, trade was carried on chiefly by means of the exchange of cattle. Hermes, the god of

herdsman, came to be regarded as the protector of merchants and as ready wit and adroitness are valuable qualities both in buying and selling, he was looked upon as the patron of artifice and cunning. The Greeks probably wronged Hermes when they said he was the god of thieves and of all persons who lived by their wits. Hermes was gifted with cunning and dissimulation from the cradle. He stole the oxen of his brother Apollo a few hours after he was born. Apollo charged him with the theft, but the child denied all knowledge of it and asked what sort of animals cows were. Apollo threatened to throw him into Tartarus, but to no purpose. He was taken before his father in the council-chamber of the gods. Zeus listened to the charge of Apollo and sternly demanded of Hermes that he should tell where he had hidden the cattle. Hermes, in swaddling clothes, looked up into his father's face and said, "Now, do I look capable of driving away a herd of cattle, I who was only born yesterday and whose feet are too tender to tread in rough places? You know well that I am not guilty, but if you wish I will affirm it by the most solemn oaths." As the child stood before him looking the picture of innocence, Zeus could not help smiling at his cunning and cleverness, but being aware of his guilt, commanded him to conduct Apollo to the cave where he had concealed the stolen cattle, and Hermes, seeing that further subterfuge was useless, unhesitatingly obeyed. It remains to be seen whether the National Association of Colleges can make Hermes restore the stolen cattle to his brother.

I believe the Association will punish those commercial travelers who, while violating the fundamental principle and object of the organization, are claiming to be in good standing as members.

The purpose of the Association of Medical Colleges has been in a measure thwarted by schools allowing students to enter college at least one month after the beginning of the session, which in four years shortens the curriculum nearly one session. It is therefore to be hoped that the College Association will per-

emptorily insist hereafter upon closing the matriculation books at the expiration of one week after the opening of the session.

The elevation of standard will be achieved despite all obstacles. The opposition seems to me to be prematurely inflicting on themselves a punishment that is said to be a method of torture in the lower world; they are carrying water up hill in a sieve—a never-ending and useless task.

There is a bit of history connected with this National Association which I want recorded not only in the minds of my hearers, but in your note-books, because memory is often treacherous and sometimes it is so convenient for our contemporaries to forget.

Professor Eugene F. Cordell M. D., of the Woman's Medical College of Baltimore in 1890 requested that delegates be appointed by every medical school in this State to meet and organize a State association of medical schools. At the meeting, Professor Aaron Friedenwald, M. D., of the College of Physicians and Surgeons of Baltimore, offered a resolution, which was adopted, that a call be made for a National Association of American Medical Colleges to meet in Nashville, Tennessee. The call was made upon all the regular medical colleges of this country. At the first meeting Professor Friedenwald was elected First Vice-President in token of his having as a member representing this Faculty originated the Association.

We have pride in our being one of the four schools of Baltimore that have remained loyal to the requirements of the National Association of Medical Colleges. We will stand up to the four-year requirement at any sacrifice, that we may help to elevate the tone and standard of medical requirement, that we may aid in making our profession the more respected at home and abroad. Let me tell you that all through your lives as doctors, whether in the fledgling and struggling period, when you are at the zenith of your credit and achievements, aye, when in the feeble climacteric of your waning powers, you will ever and anon have to answer the query:

Where did you graduate? I trust that you will always have the feeling of pride and pleasure that I have had in answering that question, from one end to the other of my professional life, thousands of times.

Sometimes you might ask a man, if he isn't too much bowed down with the infirmities of age, when he graduated, and should he say 25 or 30 years since, he would take you back to the time when that wonderful, prophetic man, Dr. Oliver Wendell Holmes, had the famous discussion with Professors Hodge and Meigs as to the nature of puerperal fever, when he overthrew the theory of its being epidemic and indeed forestalled the microscope in the proof of its being a personal contagion.

Thank God for the heaven-born help and effulgent light of these our days of asepsis and antiseptics. What reforms, what life-saving, what happiness, what triumphs over pain, sickness, despair and death has been vouchsafed the human family through the divinely appointed channels of medical science.

Judge Noah Davis, when addressing the first meeting of the International Medico-Legal Association, held in New York City in April last, said: The first profession in the world is that of medicine, the church next and the law third.

Our country owes much to boards of health and boards of examiners.

Every State in the Union, if for no other reason than that of self-defence, will hereafter place a second gateway between the newly invested graduate and a practice.

There is no well-informed, fair-minded true physician to be found who will not tell you that the State boards have been a great inspiration and aid in improving the status of medical education. Ordinarily the functions of boards of health are to regulate sanitary measures, but

in a number of States their powers have been enlarged and they are charged with the execution of the act, to regulate the practice of medicine in those States. They are thus empowered to determine what medical schools are in "good standing," establishing such standards as they may see fit. This can legally be done by any State. Webster says: A diploma is merely a document bearing record of a degree conferred by a literary society or educational institution and that the right to practice medicine is intrinsically and essentially a statutory right, subject to whatever conditions the law-making branch of the government may see fit to impose, in the interests of human health and life. We will applaud the action of such boards as long as they conduct their work fairly and honorably to the candidate and his college.

Most of the medical schools being located in large cities, where there is active discussion in medical societies, large general and special hospitals and dispensaries, much the best opportunity is afforded teachers of medicine to qualify themselves thoroughly in the various specialties and abundant material is gathered for the instruction of the student. It might be argued that the preceptor and the professor are most competent to judge of the qualifications of the student. As a general rule, I believe this to be true; but it cannot be denied that health boards have done good work and will yet do more, in stirring up those schools who, in the struggle for existence, are depressing the healthy standard of requirement and I fear sometimes allowing their maternal feelings to bias their judgment. The health board is supposed to be perfectly disinterested and views the candidate's merits or shortcomings in a dispassionate light.

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LAVAGE.—To introduce the tube to lavage the stomach in a bedridden patient, who is unable to sit up, the *Philadelphia Polyclinic* says it is better to turn the patient slightly on the side, so that

if there is vomiting the fluids may readily run out of the mouth. The tube should never be retained in position while the patient is vomiting, as the vomited material may enter the larynx.

## ADDRESS

DELIVERED AT THE OPENING OF THE DENTAL DEPARTMENT OF THE BALTIMORE  
MEDICAL COLLEGE, OCTOBER 1, 1895.

*By Thomas A. Ashby, M. D.,*

Professor of Diseases of Women and Children, Baltimore Medical College.

THE first college for the exclusive education of dental students was established in Baltimore over 50 years ago. Our city may, therefore, properly claim the distinction of being the mother of dental colleges. This college is still in successful operation and enjoys the distinction of having a large number of alumni scattered over every section of our country. Following the example of the Baltimore Dental College, our oldest medical university some ten years ago established a Dental Department in connection with its Medical Department and in this act has stimulated a union between medical and dental education which seems worthy of further development. The association of these two departments of science is a step in the line of progress destined to advance the more thorough teaching of both by establishing the true relationship which medicine and dentistry should sustain towards each other.

In organizing the Dental Department of the Baltimore Medical College the Faculty of this College has followed the example of the older university and has ventured to assert its right to compete with other institutions in this line of educational work on the ground that both opportunity and circumstances seemed to favor this step and that her facilities for giving a thorough education in every branch of science warranted her in claiming the right to engage in the education of the dental student. Within the past five years this College has expended over \$150,000 in the erection and equipment of a Hospital and College plant possessing the facilities and appliances needed for the work of medical education. Anatomical, chemical, physiological and histological laboratories have been provided for the instruction of students in these fundamental branches of scientific

work. The modern education of the dental student embraces a thorough course of instruction in these branches. Many dental schools recognize that the dental student should stand side by side with the student of medicine in his knowledge of the structure and functions of the human organism. His training for the special work of the dentist should be supplemented by a general knowledge of the fundamental branches of medical sciences upon the broad principle that a knowledge of the whole is superior to a knowledge of a part. The wider his range of knowledge and experience in the medical sciences in general the more thorough is his equipment for the management of any special department. In this age of progress and technical training we must recognize the relationship between specialism and general work. The tendency of all methods of educational training is in the direction of specialization. The field of knowledge in any one science is too extensive to admit of thorough cultivation and skilful work of the entire field. Division of labor has become the necessary outcome of all methods of work and we witness the growth of specialization from day to day in every branch of learning and of human activity. But with the growth of every specialty it is further recognized that perfection in a special field is favored by a knowledge of the whole field. The mind is broadened by general culture, while greater facility is given to the perfection of detail and a larger scope of special knowledge by reason of the broader foundation upon which it is erected. In the practice of medicine and surgery no one can question the value of knowledge obtained from the fundamental branches of medical sciences. These branches are the frame-work upon which

the physician and surgeon must build. Each may specialize in many directions and become more proficient in each special branch yet all must recognize the value of the foundation upon which he is building. We may divide the human organism into many parts. We may deal with organs, with apparatus or with the whole, but our management of an organ or apparatus is vastly improved by a general knowledge of the whole. This leads me to the special point to which I wish to refer: "The relation of dentistry to medicine."

The mouth and teeth constitute a special apparatus essential to human life and health. They are as useful and necessary as they are conspicuous, yet the tendency in the past has been to attach too much importance to the cosmetic effect of the teeth and too little importance to their value in preserving health. No organ or apparatus performs more work than the mouth and teeth. Apart from their value in the mastication and preparation of food for the digestive process, the mouth is in constant use as an organ of speech and respiration, to say nothing of its value in giving expression and character to the human face.

If the eye cannot say to the hand, "I have no use for thee," how much less can we comfortably dispense with the healthful functioning of the mouth and teeth? The aim of the dental art and science is to correct all defects of both mouth and teeth, to preserve the harmony of the expression by preserving the teeth or by restoring those which have been lost by disease or accident. Art has made immense strides in correcting the defects of nature. From a purely mechanical standpoint the progress of dentistry has been most remarkable, since it has overcome not only defects of development, but the results of those acquired by accident or disease, giving both beauty to the mouth and face in many instances and providing a more healthful functioning of the entire digestive apparatus. A simple study of the mechanical side of dentistry is, however, insufficient. As much as we may value the cosmetic side of the dental profession, a larger view of its

scope of work must be taken. It is the aim of the present system of dental education to strengthen the idea that dentistry should be classed among the learned scientific professions, that the dentist should be a man of education, of science and of liberal culture. It is believed that he should know as much anatomy, as much physiology, as much chemistry and as much pathology and histology as the physician or surgeon, with a supplementary knowledge of dentistry. There is no reason in fact or in theory why dentistry should not be a specialty of medicine. While it may not be necessary for the dentist to know fully all about disease, or be expected to do all classes of medical and surgical work, he should be expected to know as much about such subjects as the oculist or laryngologist, who confine their skill to one or two special organs. The more thorough education of the dentist in the medical sciences is certainly to be desired even if not absolutely essential to the strict work of his profession, and I believe the time will come when dentistry will become a post-graduate medical course rather than a separate educational department.

The line of work mapped out for the students attending the Dental Department of the Baltimore Medical College is an aim in the direction above indicated. Whilst we do not hold that the dental student should complete an entire medical course, we do hope that it will stimulate an advance in that direction and ultimately lead to the growth of the idea of post-graduate education. In the fundamental branches of the dental course it is believed the dental student will hold his own with the student of medicine and if then he turns aside to the legitimate study of dentistry he will be the better equipped for the practice of the science and art of dentistry. It is, therefore, hoped that every student of dentistry attending this school will recognize the importance and value of the medical training imposed on him and that he will bring to the study of the medical branches the same enthusiasm which prompts him to perfect himself in the purely dental branches.

Taking this view of his educational work the Faculty of the Baltimore Medical College will feel that it has made no mistake in organizing a dental department and in giving encouragement to this broad and intelligent view of dental education. The gentlemen of the dental profession associated with the Medical Faculty in this work of higher dental education have provided every facility for the successful education of the student in dental work. Their aim is more final and lasting, since they must make the dentist the master of his art and science while we of the medical faculty only strengthen and broaden the foundation on which he stands. With a clear understanding of our respective responsibilities and duties, we now enter upon this work, having full confidence in its success and future progress. Following the progressive and enlightened policy of the parent college the Dental Department will not want in en-

ergetic and judicious management. Having once inaugurated this undertaking there will be no backward step. Whatever redounds to the interest and advancement of the dental school will receive the support of the Faculty of the Baltimore Medical College. The parent will not lack in zeal and love towards its first-born offspring, but will strive to hasten its development and growth by every legitimate means within its power. To you, gentlemen, who begin with us this opening session we bespeak words of encouragement and good cheer. We ask you to do your part. We will strive to do ours, and we cherish the hope that you may some day feel pride and satisfaction in the reflection that you were members of the first class of the Dental Department of the Baltimore Medical College. May this fact redound both to your honor and to the honor of this school.

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LARGE PROBES IN THE TREATMENT OF LACHRYMAL OBSTRUCTION.—S. Snell (of Sheffield) reports in the *Ophthalmic Review*, vol. xiv., No. 162, his experience with the use of large probes as advocated by Theobald. He employs probes ranging in size from 1.25 to 4 mm., not numbered after the usual plan, but with the size in millimetres stamped upon them. After slitting the canaliculus he does not, as a rule, begin with the smallest probe. If the 1.5 mm. will pass it is succeeded by the 2 mm. and 2.5 mm., or it may be by the 3 mm. The next day the largest probe previously passed is again used, followed by the next size. The patient is not seen again for two days, then for three or four days, then for a week, until four or five weeks elapse. If the case is satisfactory, attendance will then cease. It is rarely necessary to use the 4 mm. probe, but the 3 mm. is constantly required, and less frequently the 3.5 mm.

Snell finds his experience after sixteen years most satisfactory. The bulk of cases are cured or very much benefited. Those in which improvement does not take place are very few.

THE DIAGNOSIS OF DIPHTHERIA.—Dr. Hermann Biggs (*British Medical Journal*) discussed the subject under three heads: 1. He recommended the examination of the throats of healthy persons who had been in contact with diphtheria, or who were inmates of institutions in which diphtheria prevailed, these examinations to be made with relation to prophylaxis, both with a view to the isolation of those in whose throats the diphtheria bacilli were found, and to the immunization with diphtheria antitoxin. 2. He recommended also examinations in cases of throat inflammations for diagnosis. 3. Examinations should also be made at short intervals during convalescence from diphtheria, to determine the time of disappearance of the diphtheria bacilli from the throat. In connection with this discussion he described briefly the methods employed by the New York City Health Department in making these examinations and the technique of the laboratory work. The paper was founded on experience gained from the examination of about 25,000 cultures by the New York City Health Department.

**CORRESPONDENCE.****INDEX MEDICUS.**

Editor MARYLAND MEDICAL JOURNAL:

PHILADELPHIA, Oct. 1, 1895.

*Dear Sir:*—The *Index Medicus*, as you doubtless know, has ceased to exist, because the number of subscribers was not sufficient to pay for its publication. Its value was so great that the undersigned, a self-constituted committee, have concluded to appeal to the literary workers of the medical profession to unite in reviving it. The nature of the *Index* is such that it can never obtain a large subscription list, but is invaluable to those engaged in literary research. It will require about \$5000 annually to publish it. The former editors are willing to take up the work again if 200 subscribers at \$25 per year can be obtained. We have each agreed to subscribe for a period of five years; will you not do likewise, and mail the accompanying blank, duly signed, to the Secretary of the Committee? If the term seems too long, will you not fill in the blank for three or less years? The Committee also begs you to get as many of your friends as possible to subscribe, and to send to the Secretary the names of any person, society or library likely to become a subscriber.

Yours truly,

WILLIAM PEPPER,	J. M. WHITE,
S. WEIR MITCHELL,	W. W. KEEN,
H. A. HARE,	GEO. M. GOULD,
DEF. WILLARD,	J. H. PACKARD,
J. C. WILSON,	E. LAPLACE.
H. C. WOOD,	
JOHN B. ROBERTS, Secretary,	
1627 Walnut St., Philadelphia.	

DR. E. FLETCHER INGALLS of Chicago has collected the data of fifty cases of goiter (*Journal American Medical Association*) treated with desiccated thyroids from the sheep, the cases coming mainly from his own practice. The remedy was given in two grain doses three times a day. The treatment was quite as effective when administered internally as when given hypodermically.

**MEDICAL PROGRESS.**

**THE DANGERS OF THYROID EXTRACT THERAPY.**—In spite of the many advantages (*American Medico-Surgical Bulletin*) accorded to thyroid extract medication in various pathological states, such as myxedema, Basedow's disease, lipomatosis, etc., the author believes the time has come to call attention to the dangers of this method of therapy. In large doses thyroid extract is a poison to the heart, as is proved by cases of sudden death from paralysis of the heart, following administration of the thyroid gland of the sheep. Hence, too much emphasis cannot be laid upon the necessity of caution in the employment of the remedy. The pulse is the best guide in these cases, and it must be daily observed. A useful procedure consists in confining the patient to bed, or, at least, to his room and forbidding all forms of exertion which might tend to increase the labor of the heart. These rules are also to be adhered to after the conclusion of the treatment, for the thyroid extract appears to possess the same cumulative action as digitalis.

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**STRYCHNINE DELIRIUM.**—The members of the medical profession who have employed caffeine very largely in the treatment of cardiac and renal disease (*Therapeutic Gazette*) have recognized that large doses of this drug, continuously administered for a considerable period, developed in certain individuals what has been properly called "caffeine craziness." In other words, the full medicinal doses required by the condition of the heart or kidneys have also been sufficiently large not only to produce an increased activity of the brain, such as is seen when coffee is taken in large amounts, but also have gone farther than this, and by the very cerebral stimulation produced temporary insanity. Within the last few years the medical profession has been employing in certain states what may be considered as massive doses of strychnine in the treatment of failing respiration or circulation, and has obtained therefrom very good results. It having been found

that these full doses of strychnine acted favorably, when given in an emergency, we have been tempted to continue their administration where the symptoms were relieved but temporarily, and as a result have oftentimes been pleased with their effect. On the other hand, a sufficient number of cases have been seen in which cerebral disturbance has followed these large doses to put us continually on the lookout for such untoward symptoms. As a rule, he who administers large doses of strychnine in an emergency is on the *qui vive* for some twitching of the muscles of the forearm or some other portion of the body as an evidence of the physiological action of the drug. While we believe that these symptoms are commonly produced by a single administration of the remedy, we are also confident that its continued administration in full doses frequently fails to produce these evidences of heightened reflex activity, and in their place causes a more or less active delirium, in which the patient frequently refuses to take his medicine, or develops the delusion that his attendants are conspiring to poison him or do him some other injury.

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CURE OF CONSTIPATION BY FORCIBLE DILATATION OF THE SPHINCTER ANI.—Dr. George L. Romine concludes an account of ten years' experience in this method of treatment as follows (*Therapeutic Gazette*): I believe that one-half of the cases have been so thoroughly cured that a dose of cathartic medicine is rarely taken, and only then through a traditional belief that such a dose is occasionally needed. In the remaining cases patients rarely have any trouble, unless during some sickness that disturbs the regular action, and this is easily overcome by mild dosing; in fact, every case of which I have any knowledge has been benefited. After these treatments some distressing reflex symptoms disappear.

Thus, in the female, persistent occipital headache, indigestion, palpitation of the heart, are often relieved by curing constipation; while, in the male, impotence and the attendant train of symptoms indicating sexual neurasthenia are

clearly recognized by specialists as frequent reflex manifestations of rectal trouble. Indeed, the importance of regular evacuations from the bowels is abundantly shown by the fact that, when called to a case, the first question asked by the physician bears upon this point. Though we are all alive to the dangers of acute constipation, we are often not sufficiently alive to the far-reaching effects of this condition when it becomes chronic.

There is, however, no class of cases where, by a little attention and treatment by the regular physician, we can hope to give our patients so much relief, and last, but not least, we can save them from a worse fate—the quack!

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THE MODERN TRAINED NURSE.—Sir Dyce Duckworth, says the *Lancet*, has always taken a deep interest in nursing, and in the Royal British Nurses Association, of which he is vice-president, and in an address delivered before this body the other day he laid great stress upon various important points connected with the profession of nursing, and not the least of these was the absolute necessity, as he pointed out, of a nurse being subservient to the medical man. The old style of nurse has so entirely disappeared that the patients and practitioners of this generation can hardly realize how much the successful treatment of disease owes to the help of an intelligent, trained woman; and this expression, *trained*, means, as Sir Dyce Duckworth clearly pointed out, not only medical and physical knowledge, but tact and silence. The abbot of a Nitrian monastery once gave one of his monks as a rule of life the first verse of the psalm commencing, "I said I will take heed to my ways, that I offend not with my tongue." "When you can keep that rule," he said, "come, and I will give you another." Tradition has it that the worthy monk never arrived at the second. Be this true or not, it shows how the tongue in all ages has been regarded as an unruly member, and all nurses ought to remember to be absolutely silent as regards anything they may see or hear outside their own im-

mediate duties. The Hippocratic oath still remains the canon for every attendant on the sick, either nurse or medical practitioner, and on this point Sir Dyce Duckworth rightly spoke with great earnestness.

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**NITROGLYCERINE IN SCIATICA.**—Mikhailine (*University Medical Magazine*) reports three cases of obstinate sciatica which were greatly benefited by nitroglycerine given in the form of the official solution in one-drop doses, three times a day. In one case, a patient, aged 44, in whom salicylates, acetanilide, phenacetine, quinine, antipyrine, bromides, massage, sedative ointments and blisters failed to give relief, the following combination was entirely successful : Nitroglycerine (1 per cent. solution),  $\text{m}$  iij to  $\text{m}$  xxx; tincture capsicum,  $\text{m}$  xc; peppermint water, 3 iij. Three drops three times a day for three days, and then ten drops three times a day.

In another patient, a nervous woman, aged 45 years, with atheromatous arteries and sciatica, associated with atrophy of the muscles and hyperesthesia, the same combination in conjunction with bromides also afforded speedy relief.

The third case was a man, aged 40 years, who suffered with fever and severe pain in the right leg. A blister over the trochanter, with sodium salicylate and valerian, lowered the temperature, but failed to relieve the pain. After the lapse of four days the nitroglycerine treatment was substituted, and this promptly lessened the pain and effected a cure within six weeks, the trouble not having returned after six months.

\* \*

**STATE COLONY FOR EPILEPTICS.**—Dr. C. Eugene Riggs, says the *Journal of Nervous and Mental Disease*, read before the Ramsey County Medical Society of Minnesota a plea for a State colony for epileptics. As he had recently come from a study of the Bielefeld colony of Westphalia, his account of this pioneer and most successful colony was very interesting. It is described as a village of 3000 people, located in a valley, and on the slopes of the hills surrounding it. Not all of the 3000 cases are epileptics.

The work seems to be done by a society of deacons and deaconesses, who act as teachers, friends, nurses and attendants. Many trades are provided to meet the accustomed work of each patient. There seems to be given but little and ordinarily no wages. Some of the occupation's pay for themselves and with a profit, others do not. Bromide is mentioned as seemingly the one drug used to combat the disease. The institution is supported as a whole by voluntary contributions.

The colony near London, the one in Ohio, and the one in California, as well as the one just planned in New York State, are mentioned with some detail. An estimate is made of from one to two epileptics to each 1000 people ; and the need of this so large a class is detailed as calling very strongly upon the State to make a light provision for the segregation, the home-like and careful care, the protection of themselves and the protection of others from them, in this and other States.

\* \*

**THE EYE IN RAILWAY SURGERY.**—Dr. C. D. Wescott of Chicago (*International Journal of Surgery*) said : An injury to the eye is the most common accident in the whole list. Hot cinders and molten metals frequently burn quite deeply into the conjunctiva. After they have been removed under cocaine and thoroughly cleaned with a bland antiseptic, a small quantity of sterilized vaseline or olive oil dropped into the eye is very soothing and grateful. It is usually best not to bandage an eye thus injured, but the lid should be frequently bathed in warm borax water and the eye flushed with a saturated solution of boracic acid every three hours. Cocaine should not be prescribed as an anodyne. Iced compresses will usually relieve the pain if applied when the pain is continuous. In our shops and factories all over the world employees are daily jabbing at the cornea with sharpened sticks, pocket-knives, horse-shoe nails, and other improvised instruments, in attempting to remove pieces of stone, steel, emery, etc., which are innocent as compared with the instruments and

methods employed. If these offending particles are not deeply imbedded in the cornea, they may usually be removed without the slightest trouble by simply wiping them away with a little swab made by twisting some cotton on the end of a tooth-pick or something like it.

\* \*

**SPLEENS IN MULTIPLE.**—Dr. Albrecht (*Wiener klinische Rundschau*) presented at a meeting of the Association of Physicians in Vienna a case of multiple spleens, entirely unique. Scattered over the whole mesentery were more than five hundred spleens from the size of a pin to a walnut. Of the latter size was the one located in the normal place, and this had a normal artery and vein. Every one had a capsule and normal stroma, though very deeply pigmented. Toldt designated the case as without a parallel in literature, or an analogue among all vertebrate animals, and the development of which was difficult of explanation. The spleen is normally developed by an epithelial proliferation of the mesogastrium, in which later the connective tissue of the mesogastrium develops abundantly. It may be conceived that in this case other portions of the peritoneum as well have acquired the capacity of spleen production. Weichselbaum discussed the question of the functional capacity of these multiple spleens. He drew a conclusion in favor of defective function both from the vicarious hyperthropy of lymph glands and from the unusual pigmentation.

\* \*

**FLAXSEED-MEAL POULTICE AS A STERILE DRESSING.**—Lovett says (*Boston Medical and Surgical Journal*, CXXXII, No. 14, p. 329), after making a series of seventeen experiments, some with and some without aseptic precaution, he determined by culture tests that these poultices are often sterile, and if not sterile contain, as a rule, organisms which are probably not pathogenic. They may contain, however, pus cocci at times, and no care in preparation can be relied on to render them sterile.

However, as an instance of the practical usefulness of flaxseed-meal poultices, he mentions his experience in some forty

cases. After operations for chronic or acute glandular abscess, which he treated in two ways. In the first series of cases a wet corrosive dressing, with perhaps iodoform, was at once applied, and so far as possible was kept continuously wet. In the second series of cases a flaxseed-meal poultice was used from the first, and was changed every two or three hours. In those treated by the flaxseed poultices the patients suffered less pain, induration disappeared more quickly, and the progress was every way more favorable than with the corrosive dressing.

\* \*

**THE HYSTERICAL BREAST.**—This is a condition which Gilles de la Tourette (*British Medical Journal*) considers of much importance, not only because it is a well-defined manifestation of hysteria, but also from the fact that it has given rise to errors of diagnosis and needless removal of the organ. It consists in a temporary enlargement of the breast, with considerable hyperesthesia of the skin covering the organ. This hyperesthesia, liable to vary, becomes much more marked during menstruation; there is then also more swelling, and considerable pain is complained of. On palpation at such a time it is possible to perceive one or perhaps two tumor-like masses in the substance of the breast, about the size of a hen's egg, but which are not painful, the hyperesthesia being cutaneous. The affection is often of long duration, more especially in those cases where there is faulty therapeusis, as often happens. It seems to depend on a hysterogenous band of hyperesthesia at the level of the breast, which induces an edema of the connective tissue of the gland. In this way are produced the local swellings, and even patches of white, pink, or violet under the skin.

\* \*

**DIPHTHERIA ANTITOXINE.**—Dr. Geo. E. Sears (*Boston Medical and Surgical Journal*) says :

In conclusion I would say that the careful observation of these cases, most of which were under my care during a portion at least of their illness, has changed my position from that of a good deal of

scepticism regarding the value of anti-toxine to one of considerable optimism. While it has not fully justified all the claims of its most ardent supporters, since death sometimes occurs even when the injections are made early in the disease, in cases which seem clinically appropriate, a marked reduction in the mortality-rate has followed its use. In the rank and file of cases the exfoliation of the membrane is hastened, the amount of septic absorption is diminished, and the danger from this source therefore decreased, while of those which are complicated by laryngeal stenosis, a smaller proportion require operation, and of these a relatively larger number recover. Even in hopeless cases the membrane may clear up under its use, while its effects in counteracting the diphtheria poison are frequently seen in the brighter mental condition and improved sense of well-being of the patient. Unfortunate results have occasionally followed, perhaps from some idiosyncrasy on the part of the patient, perhaps from some chemical change or decomposition in a particular specimen, but whatever its cause, in the face of its many advantages, such accidents should no more deter us from its use than the occasional death from ether should prevent its employment as an anesthetic, though it might suggest some limitation to its administration as a routine practice to every patient. Even if all the cases of broncho-pneumonia or albuminuria which were observed could be ascribed to it—an impossible task in a disease where such complications are common under any form of treatment—they are more than offset by a reduction of fifty per cent. in the mortality rate.

\* \* \*

FLAT FOOT.—Drs. Lovett and Dane of Boston (*Medical News*) submitted the following conclusions: 1. That the feet of the infant at birth are not flat; that a tracing made at that time resembles that of the normal adult foot. 2. That a body of fat develops under the arch which gives the appearance of flat foot for some years, and that at the age of four or five years this is absorbed. 3. That the carbon-tracing is not a per-

fect method of studying abnormalities of the arch of the foot, because it fails to detect the slighter abnormalities or to record pronation. 4. That the element of pronation is more constant than breaking down of the arch of the foot and may be entirely separated from the latter. 5. That the condition of pronated foot without breaking down of the arch of the foot should be recognized and not confused with flat foot. 6. That the treatment of pronated and of flat foot is the same, and consists in the use of proper boots, the application of a pad or plate, the stretching of the gastrocnemius muscle when it is shortened, and in the routine use of massage, and always of exercises to develop the muscles that hold up the arch.

\* \* \*

EXOPHTHALMIC GOITER.—Dr. Dixon L. Moore (*Columbus Medical Journal*) used sodium phosphate, the new remedy, for exophthalmic goiter in four cases, with rapid subsidence of all annoying subjective symptoms and gradual diminution in the size of the thyroid. In one case (recent) improvement began immediately and in less than two months the patient was practically well. In the other three improvement of objective symptoms was more gradual and cure had not been obtained; but here too the patients were at once made comfortable by the relief of tachycardia and sensations of heat and when last seen there was a marked decrease in the struma and exophthalmos.

\* \* \*

REMOVAL OF INTUBATION TUBES.—Dr. Dillon Brown showed, on May 27, 1895 (*The Canadian Medical Review*), at the meeting of the American Pediatric Society, at Hot Springs, Va., an invention of his own for the removal of intubation tubes. It is simple and works easily even in the hand of one who is not a specialist. It consists of a hook on a ring which fits the index finger. The tube is provided with a wire handle or bail on which the hook catches, when by raising the finger the tube is removed. The device is so simple that it seems likely to be of universal service.

MARYLAND  
**Medical Journal.**  
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BALTIMORE, OCTOBER 19, 1895.

WHEN a disease defies treatment in legitimate channels, it usually is taken up by quacks or makes a fortune for *Alcoholism*. some nostrum maker. The cure of drunkenness has been sought after for ages and we may seem to be approaching nearer the goal, still no specific, harmless in itself, has been discovered which will remove the desire for drink and transform a sot into a human being.

Dr. F. W. A. Fabricius, in the *Medical News*, has contributed to medical literature a very elaborate clinical picture of alcoholism in its various forms with very clear methods of treatment. Every physician has cases of alcoholism which must not only be treated skilfully for any hope of success but which must be looked after in such a way as not to attract general attention to the case, and this the author shows puts one great difficulty in the way of gaining correct statistics on this subject, as deaths from drinking are rarely recorded as such but according to the most prominent lesion.

While certain quack specifics for the cure of all forms of drunkenness as well as nervous troubles have too often failed in their attempt, it is a well known fact that this assumption of success in treatment by a secret method has stimulated the regular profession to pay greater attention to the drug treatment of alcoholism. When a person is well on the way to continual drinking or even spreeing, all appeals to moral nature or to a conscience are usually without avail. There is nothing a drinker will not do to get a drink, and that taken, other drinks follow until a state of drunkenness is the result. In the acute cases, Dr. Fabricius shows what methods are followed for the care and cure of persons who have swallowed large quantities of strong spirit in a short time. Such cases are most usually seen in hospitals.

But it is in private practice that the chronic drinker, the soaker and the one who goes on periodical sprees are seen. To treat these even without any prospect of cure requires care, skill and more tact than most persons possess. Authors differ as to the advisability of cutting off at once the alcohol altogether, or tapering off. Dr. Fabricius maintains that a too sudden withdrawal in a hard drinker will bring on delirium tremens and there may be some element of truth in this. The craving for drinks in the morning may be stilled, in part, by washing out the stomach with tepid water in which the bicarbonate of soda has been dissolved, two drachms to the pint; or if the digestive powers are weak, a drachm of dilute hydrochloric acid instead of the bicarbonate of soda may be used. Costiveness or constipation should be counteracted by appropriate remedies from the salines to the strongest cathartics. The diet should be regulated and the bitter tonics with strychnia and capsicum will be of great assistance.

One of the greatest troubles with these cases in all stages is the insomnia, which often will not yield to any drug. The bromides are usually too mild and opiates are never indicated unless a condition of mania demands them. Chloral and trional are both very efficacious in these cases, and what are especially indicated are hypodermic injections of strychnia and hyoscyamine used alternately and together, testing the patient first with a small dose of strychnia and gradually increasing the dose.

Many reformers forget in their zeal that

drinkers have a weak moral nature, and in many the craving for drink is a disease and the mere talking and persuading will have no effect, for a drinker will make any kind of promise and take the first opportunity to drink again. Therefore some such nerve stimulant as Dr. Fabricius has used must be vigorously pushed and then when the body is supported the conscience and moral nature can be appealed to with results.

In about this line will the steady drinker who wishes to reform be treated. Chronic alcoholic poisoning in which there is a connective tissue sclerosis and a degeneration of the organs may yield to the iodides but it is doubtful. Cases of periodic alcoholism are much like outbreaks of epilepsy. These cases all go the same way when untreated and they demand different methods of treatment.

The physician who undertakes the reformation and cure of one of such cases outside of an institution usually finds that he has a powerful enemy to contend with and must often persevere against the patient and the disease.

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THE value of such a publication as the *Index Medicus* has been so often impressed on the readers of this JOURNAL *Index Medicus*. that this fact hardly needs repetition, but unfortunately this publication is in danger of dying and in fact has ceased to appear, and it is the urgent wish of many in the profession that sufficient subscribers be found to continue this periodical, so useful to every reader and scholar.

The appeal published elsewhere in this issue is a direct and practical one, and it is hoped that some few of the readers of this JOURNAL will be induced to send in the sum necessary for one subscription. The plan now, as has been stated before, is to obtain two hundred subscriptions at twenty-five dollars each and then to issue the *Index Medicus* quarterly, printing two hundred and two copies, the extra two copies being for the library at Washington.

The MARYLAND MEDICAL JOURNAL will gladly receive, acknowledge and forward any subscription which may be sent conditionally. The money need not be given but simply pledged and if by the first of December the two hundred subscribers have been obtained the money will then be demanded, but if this number has not been obtained by that time the pledges will be returned.

As has been stated before in these columns, the *Index Medicus* not only benefits those subscribing, but indirectly it assists the whole medical profession, for it helps the scholar and writer to present facts of practical value to his hard-working colleague, who may have time for reading but rarely for writing. It also shows that the large number of physicians in the United States and in Great Britain as well think enough of the dignity and high standing of their calling to keep up its literature by this powerful aid. Individuals, societies and clubs have taken one or more subscriptions conditionally, but the price, apparently large but in reality very small, for this comprehensive production has frightened many away.

If all would look at this publication and consider its inestimable value to the whole medical profession there would be more money subscribed to it. The writer needs the support of the busy practitioner and the latter should willingly give his share towards supporting the literature of his profession.

The following pledge may be signed, cut out of the JOURNAL and mailed to Dr. John B. Roberts, as indicated in a letter in this issue, or it may be sent directly to this JOURNAL and will be acknowledged and forwarded to the proper place.

I, the undersigned, hereby agree to subscribe for one copy of the *Index Medicus* for year at \$25 per year, subject to the following conditions, viz.: When 200 subscriptions have been received by the Editors, the publication is to commence, and upon notification of this, I will send \$25 to them. If by December 1, 1895, the 200 subscriptions have not been obtained, the attempt to revive the publication will be abandoned.

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The signing of such a pledge involves nothing if the requisite number of subscribers cannot be obtained, and if the plan is successful the money will be well spent. According to the latest reports, between seventy-five and a hundred subscriptions are needed to complete the list and it is of course the last few that are hardest to obtain, as the field is gleaned over. It is not asked to subscribe for five years but such long terms are desirable, as when the short term expires this active canvassing will have to be repeated unless the money can be forthcoming in another way.

**MEDICAL ITEMS.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending October 12, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		11
Phthisis Pulmonalis.....		22
Measles.....	3	1
Whooping Cough.....	5	4
Pseudo-membranous Croup and Diphtheria. }	19	7
Mumps.....		
Scarlet fever.....	7	1
Varioloid.....		
Varicella.....		
Typhoid fever.....	12	5

The Baltimore Medical College has opened a Dental Department.

In the French Senate there are thirty-seven doctors and in the Chamber of Deputies fifty-eight.

In Norway and Sweden no couple can be married without producing certificates of satisfactory vaccination.

From the latest reports the health of Dr. Robert Battey of Georgia has slightly improved, although he is not yet out of danger.

Dr. Hiram Woods has succeeded Dr. J. J. Chisolm as Professor of Diseases of the Eye and Ear at the University of Maryland.

The New York Post-Graduate Medical School and Hospital has received a gift of \$5000 from the estate of the late Henry M. Cram.

The memory of the late Dr. Dujardin-Beaumetz has recently been honored by the erection of a bust in the garden of the Hôpital Cochin in Paris.

The American Climatological Association will hold its next annual meeting at Lakewood, N. J., in May, 1896. Dr. James B. Walker will preside.

Dr. Herbert Harlan takes the place lately vacated by Dr. Hiram Woods as Professor of Eye and Ear Diseases at the Woman's Medical College of Baltimore.

Pasteur's death and funeral obsequies have attracted universal attention and all have admired the simplicity and modesty of his life with the unostentation of his burial.

Dr. M. A. R. F. Carr, Secretary of the Cumberland, Maryland, Board of Health, reports that city in an especially healthy condition, with no cases of typhoid fever.

Several cases of smallpox have developed in the Indian training school at Carson, Nevada. As the pupils had just returned from their summer vacation, the origin of these cases is unknown.

The Medical and Chirurgical Faculty of Maryland has been invited to hold its semi-annual meeting in November of this year at Belair, Maryland. The arrangements are not yet complete.

Every physician of the State of Maryland, whether a member of the State Society or not, should visit the new building of the Medical and Chirurgical Faculty of Maryland on Hamilton Terrace, Baltimore.

At a recent meeting of the Trustees of Jefferson Medical College, Philadelphia, the honorary degree of LL. D. was conferred on Dr. John Collins Warren, Professor of Surgery in Harvard University.

Professor Schede, Director of the Surgical Department of the Hamburg General Hospital, has been appointed to the chair of Surgery in the University of Bonn, in succession to Professor Trendelenburg.

Dr. John S. Billings, formerly Assistant Surgeon-General of the United States Navy, and who was placed on the retired list October 1, 1895, has just entered upon his duties as medical director of the University of Pennsylvania Hospital.

Dr. A. Brothers of New York has received the award of the William F. Jenks memorial prize of five hundred dollars, under the deed of trust of Mrs. William F. Jenks, for the best essay on "Infant Mortality During Labor, and Its Prevention."

Dr. Catherine Runyon was admitted to membership in the Virginia Medical Society at its recent meeting. She is the first female physician admitted to membership. The North Carolina Medical Society has one female member, Dr. Annie L. Alexander of Charlotte, admitted in 1885.

## WASHINGTON NOTES.

The Medical Association of the District of Columbia held its semi-annual meeting on Tuesday, October 1, for election of new members. The following were declared elected: Drs. Noble P. Barnes, Lewis J. Battle, George M. Carlisle, Randolph B. Carmichael, Thomas A. Clayton, James B. Harmer, Sidney L. Johnson, Rupert Norton, James J. Richardson, Frederick O. Roman, Robert F. Sillers, Albert L. Stavely, Ada R. Thomas, William Peyton Tucker.

The Medical Society held its meeting on Wednesday evening, October 2. It was with great pleasure that the members welcomed back the President, Dr. S. C. Busey, who has been ill so long. Dr. William P. Carr read an able paper entitled "The Nature and Treatment of Tumors of the Breast." The following gentlemen were elected members of the Society: Drs. Robert W. Baker, W. M. Barton, W. A. Caldwell, Thomas A. Clayton, Randolph H. von Ezdorf, Charles W. Filler, George B. Heinecke, Phillip Jaisohn, Wallace Johnson, A. S. Maddox, W. L. Pyle, Frank R. Rich, Louis P. Smith, A. R. Stuart, Frank P. Vale.

Typhoid fever has been so prevalent in this city for some time that the Board of Trade has taken up the subject for discussion, in connection with the sewers. The Health Officer recommended and the Commissioners of the District have appointed Dr. G. M. Koher a special sanitary inspector to investigate the cause and report on it.

The Washington Gynecological and Obstetrical Society held its regular meeting on Friday evening, October 4, the President, Dr. H. D. Fry, in the chair. Dr. Fry read the President's Address. At the next meeting, which will take place on October 18, there will be an election of officers and also a dinner at the Arlington Hotel. A "Ways and Means" Committee was appointed by the President to report some way of entertaining the Southern Gynecological Society, which will meet here in November.

The Georgetown Medical College opened on September 30, the opening address being given by Dr. Sternberg, Surgeon-General of the Army. The prospects for a large number of students are very good, considering the radical change that has been made in the

school. The lectures will hereafter be in the day time, instead of at night as heretofore.

The Columbian University held its opening night on October 1. Dr. W. W. Johnston delivered the address of the evening. The prospects are very flattering. The lectures will be in the evening as before.

A competitive examination has been held for "Physicians to the Poor," to fill vacancies that will occur December 15. Fifty-two applications were filed, but only twenty-five appeared for examination. Ten vacancies will occur. The object of the examination was to raise the standard of "Physicians to the Poor." The list of applicants embraced some of the brightest young physicians in the city. The Examiners were Dr. W. P. Carr, on pathology, surgery and anatomy; Dr. R. D. Boss, on practice of medicine and bacteriology; Dr. J. R. Nevitt on *materia medica*, toxicology, physiology, chemistry and hygiene; and Dr. J. Wesley Bovée on gynecology and obstetrics.

The great alarm that has been occasioned by the occurrence of so many cases of typhoid fever seems to be slightly subsiding. A number of prominent physicians have declared that the disease was not epidemic here. They all practically concur in the opinion that it is due to the defective sewerage, inadequate water supply and polluted wells.

The regular meeting of the Medical Society was held on Wednesday evening, October 9, the President, Dr. S. C. Busey, in the chair. Dr. Jas. Taber Johnson presented several specimens, as follows: ovarian cysts, ruptured tubal pregnancy, fibroid uterus, removed by abdominal hysterectomy. He also passed around for inspection a concretion that was removed in an operation for appendicitis. Dr. L. W. Glazebrook, deputy coroner of the District, said that he had found similar looking substances in post-mortem examinations and on mashing them up had discovered they were fecal. He suggested that this one might be fecal. The President stated that a true grape seed had been recently found by Dr. William T. Bull of New York. Dr. J. Wesley Bovée presented a specimen of ruptured tubal pregnancy.

The paper of the evening was read by Dr. A. R. Shands, entitled, "The Importance of Early Mechanical Treatment in Anterior Polio-myelitis." The paper was extremely interesting and well delivered. He presented

a patient, who was suffering from traumatic anterior polio-myelitis, having received a bullet between the eleventh and twelfth dorsal vertebrae and resulting in paralysis of the gluteal muscles. He also showed a number of plaster casts representing the different types of paralysis. It was discussed at considerable length by Drs. S. S. Adams, Taliaferro Clark and F. B. Bishop. Drs. Shands and Adams maintained that mechanical treatment was the only satisfactory way of treating the disease, whereas Drs. Bishop and Clark said that the electric and mechanical treatment should be carried on at the same time.

The Faculty of the Medical Department of the Columbian University have decided to have a museum in connection with the University and have appointed the deputy coroner of the District, Dr. L. W. Glazebrook, as curator. They are anxious to have specimens. Each specimen will have a label on it, telling the number, the specimen and by whom it was presented.

On Thursday evening, October 10, at the office of Dr. H. L. E. Johnson, the following gentlemen met and organized the Post-Graduate School of Medicine of the District of Columbia, viz., Drs. H. L. E. Johnson, E. L. Tompkins, James Kerr, G. Byrd Harrison, G. Wythe Cook, S. S. Adams, G. N. Acker, M. F. Cuthbert, C. W. Richardson, E. M. Parker, W. H. Wilmer, S. C. Busey, W. W. Johnston, J. Ford Thompson, Henry D. Fry, J. Foster Scott and T. E. McArdle. Dr. S. C. Busey was unanimously chosen Chairman and Dr. G. Wythe Cook, Secretary. A committee was appointed to draw up a constitution and by-laws. The meeting then adjourned, subject to the call of the committee. The object of this organization is to promote clinical teaching in the District and all of the gentlemen connected with it have connections with the various hospitals of the city.

## PUBLICATIONS.

*The Liver as an Organ of Elimination of Corpuscular Elements.* By Gustav Fütterer, M. D., Chicago. Reprinted from *Medicine*, August, 1895.

*The Treatment of Anal Fissure, or Irritable Ulcer of the Rectum.* By Lewis H. Adler, Jr., M. D. Reprinted from the *American Lancet*, March, 1893.

## CURRENT EDITORIAL COMMENT.

### MEDICAL COMPETITION AND PICTURES.

*The Medical News.*

EVERY person has been amused, as well as disgusted, by the rage for illustrations that has seized upon the community. The old-time advertisements of the powers of the actor or the virtues of some nostrum are now replaced by portraits and illustrations infinite in number and variety and execrableness. The "regular" profession is imitating the quacks in this respect, and catalogues, prospectuses, and reports of sanitaria and hospitals may contain more pages of pictures than they do of text.

### CROWDING THE PROFESSION.

*Canadian Medical Review.*

IT is said on reliable authority that there are not more than nine physicians in Toronto making over six thousand dollars a year in practice, and that 40 per cent. of the practitioners in this city do not collect a thousand dollars a year. We think we have shown reasons for believing the profession of medicine to be full to overflowing; and we doubt very much if it is not cruel and a great wrong on the part of anyone to advise young men to enter its ranks, unless he be one of the rare individuals blessed with a competency, or one whose social position will advance him without the usual "weary waiting."

### CHICAGO SEWAGE CANAL.

*Kansas Medical Journal.*

AS THE great Chicago sewage canal progresses people along the Mississippi are becoming alive to the dangers that threaten them. Chicago is certainly very unfortunate in its natural drainage facilities, but it does not seem just that the health of other cities of the same and other States should be sacrificed for its relief. The serious question to be considered in connection with the Chicago canal is the danger to other cities. It is claimed that there will be complete oxidation of all organic matter before it reaches any of the threatened cities. The interest that has been awakened in the American Health Association and in the local sanitary boards would indicate that they had considerable doubt of the purifying effect of the air and current.

# MARYLAND MEDICAL JOURNAL

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## ORIGINAL ARTICLES.

### THE LESIONS ASSOCIATED WITH DYSMENORRHEA.

READ BEFORE THE GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE,  
OCTOBER 8, 1895.

By William S. Gardner, M. D.,

Associate Professor of Gynecology, College of Physicians and Surgeons, Baltimore.

It has been long recognized that painful menstruation is associated with, if not due to, some pathological condition usually of such a character that it can be readily recognized and often corrected. There is a limited number of cases where no gross lesion can be detected. And even when there occurs a gross lesion of the internal organs of generation it does not necessarily follow that the dysmenorrhea is due to the lesion or that the curing of such a lesion as is found will necessarily relieve the painful menses.

But from a careful clinical study of the lesions found associated with painful menstruation, we will learn more about the direct causal relations between the lesions and the pain, and consequently learn more about the relief of this trouble, which not only makes many a woman uncomfortable but unfits her for duty during from 10 per cent. to 25 per cent. of the active period of her life.

I have taken 120 cases that have complained of painful menstruation and have attempted to classify them according to what appeared to be the most important lesion detected. Among the 120 were eight nulliparae who on account of an intact hymen on the presumption of its presence were not examined digitally; this leaves 112 who were examined.

One of the most striking points noted is the very large number of sterile women ; 44, or a fraction less than 40 per cent., belong to this class. Of those who had been pregnant, 12, or over 10 per cent., had never had a child at full term ; 15 more, or 13 per cent., had had a miscarriage since the last full term child was born, leaving less than 37 per cent. of the total number whose last pregnancy had come to full term. Without further examination these figures would indicate that in a large proportion of patients suffering from dysmenorrhea there were present lesions which also interferred with conception.

A detailed account of all these cases named would be very tedious, and I will give the list of lesions found and then make some comments upon a part of them. It should be borne in mind that the lesion noted was not necessarily the only one present but was the most marked lesion, and presumably the one to which the pain was due. I say presumably because we find these same lesions in patients who have no dysmenorrhea, but to go into the relations of all these lesions to dysmenorrhea would lead us further than the limits of this paper would allow. Of the 112 patients examined the following were found :

Endometritis . . .	23
Retroversions . . .	14
Pyosalpinx . . .	17
Anteflexions . . .	14
Laceration of Cervix } and Endometritis }	10
Cervical Stenosis . . .	8
Constipation . . .	7
Retroflexions . . .	4
Enlarged Ovaries . . .	4
Fibroids . . .	2
Prolapsed Ovaries . . .	2
Prolapsed Uterus } . . .	1
Lacerated Cervix }	1
Membranous Dysmenorrhea 1	
Nothing found . . .	5
	112

Of the 23 in whom endometritis was apparently the most marked lesion, 9 had had their last pregnancies terminate in abortions; 5 are known to have had gonorrhea, and of the 8 in whom nothing further than a cervical endometritis was noted it is highly probable that a considerable number had had gonorrhea. Only one case that was probably a corporeal endometritis was noted.

Of the 18 retrodisplacements, 13 were retroversions in which no adhesions were detected; 3 retroflexions with no adhesions, and 1 retroflexion and 1 retroversion with adhesions. Two other retroversions with pus tubes are in the list of pyosalpinx cases.

Of the 17 cases of pyosalpinx, 9 were of gonorrhreal origin, 2 probably puer-

ENLARGED BURSAE ABOUT THE KNEE.—Roncali (*British Medical Journal*) describes seven cases of enlarged bursae about the knee, six of which were operated upon with complete success; in one (an interesting case of enlarged bursa under the quadriceps extensor, and not communicating with the joint) the patient refused operation. The seventh case was of a man, aged 25, who fell on his left knee in January, 1893, eight days after which the knee became swollen and remained so for five months, then entirely disappeared. In August of the same year he noticed a swelling in the left popliteal space, which was rapidly increasing, causing a sense of weight and weakness in the limb, but no pain or fever. The popliteal artery could be felt beating over the

ral and the remaining 6 were due to an infection which could not be traced directly either to gonorrhea or to a puerperal infection.

Ten of the 13 anteflexions had never been pregnant; the other 3 having been pregnant one or more times. At least 1 of the 10 is known to have become pregnant after dilatation and gauze packing had been used. This patient had also had gonorrhea.

In 3 of the 8 cases of stenosis of the cervix the lesion was due either to a cicatrix forming after operation on the cervix or after laceration.

The patient suffering from membranous dysmenorrhea made but one visit. She brought with her a complete cast of the interior of the uterus and said that she had passed such a cast at each period since her last confinement, which had been five years previous to the visit.

From these cases it is seen that 100 out of 112 patients suffering from painful menstruation, who were examined with a reasonable degree of care, were found to have some marked organic lesion of the internal generative organs.

The practical conclusion to be drawn is that dysmenorrhea being due in nearly all cases to some local trouble, the treatment for its relief must be directed toward relieving the local disease.

tumor. On examination the swelling was seen to be divided into two parts by a sulcus, the upper section as large as an eight months fetal head, the lower and outer about the size of an orange. Pressure on the tumor caused no diminution in its size or alteration in the form of the joints. The circumference at the upper margin of the patella equalled 58 cm., as against 36 cm. on the right side; below the patella 42 cm. left, 32 cm. right; left calf 38 cm., right 37 cm. An incision was made over the tumor and the bursa, with three cysts, firmly adherent to the posterior surface of the capsule of the joint, was removed. There was no communication with the joint. The patient was able to leave the hospital two months after, completely cured.

## EVIDENCE OF SEPSIS AT INCEPTION OF ABORTION.

READ BEFORE THE GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE,  
OCTOBER 8, 1895.

By John Neff, M. D.,  
Baltimore, Md.

EVIDENCE of sepsis at beginning of abortion, or before the occurrence thereof, is something so rare, that I have deemed a brief report of two cases not unworthy the attention of the Society. That sepsis frequently attends and follows abortions in the later stages, when the debris has undergone putrefactive changes and been allowed to remain, has been frequently observed, but oftentimes this neglected condition does not entail evil effects, as nature's resistant barriers prevent the encroachment of the deadly bacilli, and healthful conditions replace the morbid ones.

April, 1887, 9 o'clock A. M., I was called to Mrs. M. aged 27, for consultation with a doctress. A miscarriage had taken place ten days previously. Her temperature was  $104^{\circ}$ , pulse 140, feeble and compressible, patient bathed in profuse perspiration, countenance of dusky hue, abdomen distended and flatulent, painfully tender, especially in ovarian region. Examination of uterus revealed some remaining purulent debris.

Curettetment was employed and intrauterine injections of permanganate of potash 5 gr. to oz.—afterwards daily antiseptic vaginal douches of dilute solution of chlorinated soda. But these only ameliorated her condition, as general sepsis was present. Her condition continued serious for ten days more, when convalescence began and continued to recovery. After regaining her health fully she again became pregnant and went to full term and passed through a lying-in period with no unfavorable symptoms. After two years elapsed she became pregnant again, but at the end of two months suffered a tedious miscarriage, but with none of the ill consequences of the first. In reasonable time she again became pregnant and passed through safely to full term and favorable delivery and prompt restoration. Being of prolific nature and habit, in due

time she conceived and after the lapse of two months the abortion which I deem of rare interest in its results, and which I now report, took place.

On the morning of the 9th of April, 1894, she noticed some slight hemorrhage and pain, which became persistent and frequent during the day. At midnight she had a prolonged chill, followed by high fever and profuse perspiration. When I saw her early the next morning her temperature was  $104^{\circ}$ , pulse 130. On digital examination I found the os resistant and only slightly pervious, hemorrhage slight and pain trifling and infrequent. Thinking the abortion might be prevented, as it had not been criminally induced, I enjoined absolute rest and gave anodynes. At my next morning visit the temperature was still  $104^{\circ}$  and pulse 130; frequent chills had occurred during the night and now the miscarriage was inevitable, the fetal portion having passed during the night. The os was now patulous and easily dilatable and the dull curette was used to remove the remaining portions. Intrauterine douche of permanganate of potash 5 grs. to ounce, followed by copious use of sterilized water. Thus within a brief time after inception of abortion the uterine cavity was emptied of its contents, which were healthful, was antiseptically treated, the temperature remained high, the irregular chills were frequent. During the night arthritic trouble developed in the right shoulder and left knee, the joints became swollen, sensitive and painful. Effusion rapidly took place in knee joint, distending the joint more and more each day. The fluctuation seemed to indicate a fluid that was purulent in character, if not already pus. Aspiration was decided upon on the 17th, and employed, taking from the part ten ounces of sero-purulent fluid, which undoubtedly would have become pus if allowed to remain

and proven destructive to tissues of the joint. No more rigors occurred and the pulse fell to 96 and temperature to 100° within a few hours after the operation. The joint did not refill, but motion was impaired for several weeks and four months elapsed before normal restoration occurred. No effusion took place in the shoulder joint, but the arm was painful and its use impaired for two months.

The effusion in knee joint was doubtless of septic origin, as it began almost simultaneously with inception of the miscarriage. There was slight tenderness in pelvic region, but no distention of abdomen or peritoneal investment.

The treatment was sulphide of calcium, grs. 3 every 4 hours, alternated with salicylate of quinine, grs. 5. Full nourishment and moderate stimulation. Hypodermics of morphia to allay pain of joints.

The other case was Mrs. C., aged 26, mother of two children, youngest 18 months old. Had missed two monthly periods and on December 21, the date for its usual return, she noticed slight hemorrhage and irregular pains. In this condition took a long shopping jaunt that afternoon and evening; the weather was intensely cold. After retiring, she was seized with a prolonged chill, which repeated itself a second time, followed by fever and profuse perspiration. When I saw her in the morning I found her temperature 105°, pulse 130. The hemorrhage was still slight and uterine pains infrequent and short. The os being impervious, the miscarriage did not seem imminent. During the next twenty-four hours, the

**EXTERNAL APPLICATION OF GUAIACOL IN ORCHITIS.**—Pietro Pucci (*British Medical Journal*) reports the case of a man, aged 66, who had suffered from repeated attacks of ague. Inflammation of both testicles suddenly came on without any apparent cause, and this was followed within two or three days by an acute attack of malarial fever. Sulphate of quinine was given for a week without any effect on the fever, while belladonna was applied to the testicles, equally to no purpose. An ointment composed of

irregular chills and high temperature were maintained and the abortion now seemed inevitable, some fragmental tissue having passed and the pain and hemorrhage increasing. The abdominal tenderness was now marked and especially in the right ovarian region was tense and most sensitive. It now seemed impossible to prevent the abortion and I dilated and removed the contents, which showed no putrefactive change. Employed intra-uterine injections of hot carbolized water. The lochia continued natural and inoffensive, still antiseptic vaginal douches were employed daily.

The second day she complained of pain in her right hip joint and I readily recognized the beginning of arthritic trouble, that existed in the previous case just reported. The pelvic tenderness continued; by palpation I detected enlargement and infiltration of the right ovary and tubes. The temperature, even with large doses of quinine and antifebrine, continued high, ranging from 103°, A. M., to 105°, P. M.

The arthritis lasted three weeks in the acute form and impaired the use of the joint two months. The pelvic tenderness and infiltration subsided with the acute arthritic symptoms and tedious convalescence began. The treatment employed was large doses of sulphide of calcium and salicylate of quinine, alternating with saline and cold water bag on groin and hip when the temperature was highest. Gave nourishing diet and mild stimulation; hypodermic injections of morphia to alleviate arthritic pain and to induce sleep.

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2 grains of guaiacol and twenty grains of vaseline was then prescribed, about 2 grains of it being painted over the scrotum thrice daily, and the quinine being discontinued. The result was that the fever was almost at once subdued, and the orchitis was entirely cured in a week. The immediate effect of the guaiacol was an intense burning sensation at the place where it was applied. This lasted about ten minutes, but half an hour after the application the pain was mitigated and finally ceased.

## THE HOMICIDAL CRANK.

READ BEFORE THE ALLEGHENY COUNTY MEDICAL SOCIETY, PITTSBURG, PA.

*By Theodore Diller, M. D.,  
Pittsburg, Pa.*

A YEAR or two ago a man about fifty years of age came into my office and asked me whether I understood hypnotism. When I told him that I had made some study of the subject, he asked me to remove a "hypnotic spell" which was upon him. He went on to say that he was constantly kept under hypnotic influence by a certain man who lived in the same village in which he resided. He stated that a couple of years previously he first became aware of a certain malign influence exerted over him by hearing, while working at his trade (that of a barber), voices which accused him of incompetence and certain crimes and misdemeanors. These voices, heard rather infrequently at first, visited him oftener as time passed on. He grew to believe that his secret thoughts were read; that all lack of success and mishaps and accidents of various kinds were due to some evil influence which was exerted over him. He told his wife and friends of this malign power to which he then believed he was constantly subjected, and when they would not agree with him in his ideas, conceived the belief that they, too, were dominated by the same evil influence which had rendered him powerless. He said that he was compelled to give up his trade because the evil person who now governed his every thought and action prevented him from shaving properly, or indeed doing anything correctly. He came to believe shortly before coming to see me that the evil influence dominating his whole life was exerted through hypnotism, and then naturally cast about to find the author of this strange and marvelous influence. He thought of several persons, and at first could not be sure which was the one on whom he should blame his troubles. But at the time he had called on me he was quite sure

he had found the real author of all his misery. He named this person to me, and with flashing eye and angry expression denounced him soundly. He declared that even at the very time he was talking to me he could hear his persecutor distinctly speaking in his ear saying that I could not in the least help him, and casting reproaches on me.

My explanation to him that all these ideas were vagaries of the mind brought about by an illness from which he was suffering, was, as you may readily suppose, not received.

I engaged him in conversation on indifferent subjects, and found that he was rational and intelligent when talking of these matters. I subsequently exhibited the man before the Pittsburg Academy of Medicine when the symptoms I have outlined were exhibited, for he was quite ready to converse.

When he had left the office, I at once wrote to his wife to call upon me, which she did some few days later. I urged her as strongly as possible to place her husband in an asylum at once, as he was a very dangerous man and might at any time attempt to kill the man whom he believed was keeping him constantly under hypnotic influence. She refused to do this because her husband was "so sensible" in many ways. She doubted whether his "peculiar ideas" were enough to constitute insanity. The man came back several times, each time telling the same story. He, however, became convinced that I was unable to remove the hypnotic spell which was upon him, but sought my aid in helping him to have his Svengali arrested and placed in prison. He said he wished to act within the law, but that if he failed in this, he might be constrained to take the law in his own hands.

Seeing that his wife was unwilling to

act, I then with the approval and advice of several Fellows of the Academy wrote a short statement of the case to the Burgess of the town in which he lived, strongly urging that steps be taken promptly to place the man in an asylum. So far as I know, this has never been done.

While it is true that this man may never attempt homicide, I believe you will all agree with me that with the delusions and hallucinations he possesses, he is a great source of danger while at liberty to go about as he pleases.

I have purposely related this case at some length, as it is an excellent type of many so-called "homicidal cranks," and illustrates well some difficulties encountered in dealing with them.

This man's wife regarded him as "peculiar," but not insane. Yet the possession of those very reasoning powers which made his wife hold that he was not insane, rendered him, with the delusions and hallucinations he possessed, all the more dangerous. The old idea among the laity that to constitute insanity there must be great emotional disturbance or entire dethronement of reasoning faculties still largely prevails. So it happens that friends of the chronic delusional lunatic or paranoiac who constitute most frequently the "homicidal crank" are unwilling, as in the instance cited, to have him detained in an asylum. But they are often willing to have him so committed after he has killed someone and an indignant community are demanding that the death sentence be passed upon him.

Last summer a mechanic somewhat past middle age was admitted to St. Francis Hospital, not so much because he was insane as because it was feared that he would commit murder. In my first interview with him, I was, as is often the case, unable to discover any evidence of insanity. Before seeing him again I learned of delusions he entertained, and was, at my second visit, easily able to learn the character of his insanity. For some months past, he had believed that his wife was unfaithful.

He stayed home from work very fre-

quently to watch her, but even then he was convinced that she carried on illicit relations with different men. Every man who came to the house for any purpose was suspected. He stated that as many as six men had intercourse with his wife in a single night, and moreover affirmed that his own daughters shielded her in her infidelity and kept a large black monkey about the house which in some way assisted them. It was noticed shortly before the unfortunate man was brought to the hospital that he had put in repair and loaded an old pistol which was about the house, and in speaking to me afterwards he said that it had been his intention to shoot some man when he was quite sure of his guilt. This action very properly determined the family to place the unhappy man in the hospital.

Here we have a case of paranoia, another type of the "homicidal crank." I think it will be readily conceded he might easily commit homicide.

Another type of paranoia is that characterized by great exaltation of the ego, together with delusions of persecution. Here the subject wishes to lead the Nation, reform a great city, create a new religion, offer an easy plan for the settlement of political difficulties, etc. Finding, of course, difficulties in attaining his end, he logically sets about to ascertain the obstruction, and this he often finds to be some individual of great prominence. Frequently his attention is called to the individual who stands in the way of his own greatness, and the success of a great cause by some public discussion or dispute in the newspapers which brings the said individual into great prominence. Thus Guiteau thought to unify a great party by killing President Garfield; Berkman sought to simplify the labor trouble by attempting to kill Chairman Frick; while Prendergast believed he would cleanse and promote the progress of Chicago by killing Mayor Harrison. At some time or other attempts on the lives of most European Sovereigns have been attempted by the "homicidal crank." Indeed it may be said of him as of Death that he loves a "shining mark."

What is to be done with him? The question may be divided into two parts.

1. Before he has attempted or committed homicide?

2. After he has attempted or committed homicide?

The first of these two questions presents the greater difficulties. In the first place, not all so-called "cranks" are homicidal. Indeed many of them, I believe, may be safely left at large undisturbed. But in general, I should say that those who entertain systematized delusions of suspicion or persecution, especially in connection with exaggerated ideas of self-importance, ought to be under restraint. How and by whom is this class to be sought out and by what legal process restrained? These are the vital questions in connection with the matter. Obviously, it would be impracticable for the authorities to appoint special examiners to go about seeking out the "cranks" in the community. But it seems to me that much could be done by members of our profession to educate the public to some intelligent understanding of the dangers to which society, particularly some prominent individuals in the same, are ever subject while certain of these "cranks" remain at large. Many of them are brought to the physician's notice in some way or other; and in that large conception of our professional duties which clearly points that ministering to those actually sick, mentally or physically, does not by any means comprise our whole duty; but that it belongs to us to go farther and warn families and the public generally against mental and physical harm which may be threatening. With a clear understanding of the nature of these cases of chronic delusional, alcoholic, epileptic, and other insanities which may bring forth the homicidal crank, and with this broader view of our relations and duties to society, the physician may do much to lessen the number of murders by "homicidal cranks" at large. Nor should we be discouraged if our efforts sometimes prove futile. In the first case I have reported, looking upon my duty to the public as of paramount importance, and

in my unsuccessful efforts to get the man in an asylum beyond the reach of harming anyone, I revealed so much of professional confidence as seemed to me might be necessary to accomplish that purpose. It is very probable, however, that in reality, I revealed nothing that was not already well known. But I could easily conceive of cases which might arise where, in the discharge of his duty to the public, the physician might be called upon to reveal much of a private nature. In delicate or doubtful cases, however, he should seek counsel before doing so.

I believe that persons who, by their actions, seem to be mentally deranged and seek interviews at the White House, with the various Governors and prominent individuals, and who haunt our courts and legislative and other bodies, should promptly be arrested and examined by competent physicians as to their mental condition.

If after such examination they are shown to be "cranks" of dangerous tendencies, they should by some appropriate legal process be remanded to an asylum. I believe this matter should be taken up and pushed vigorously. At very short intervals, the newspapers furnish accounts of the doings of the "cranks" at the White House. Unless he commits some overt act, I believe he is not arrested nor are efforts made to institute any legal inquiries as to his sanity. While many of these "cranks" are doubtless harmless, one must believe that some would under certain circumstances commit homicide. Extraordinary measures have been taken to protect the President during the past few years against the "crank." It seems to me that in Washington the method of inquiry I have suggested could be most profitably instituted, for the Capital of the Nation draws and will continue to draw large numbers of "cranks" to it, largely because their delusions of greatness take a political complexion, and the seat of the Government naturally becomes a sort of Mecca for them.

After he has committed a homicide, what shall be done with the "crank"? Certainly he should not be hung. I

cannot endorse the Spartan method of Dr. Wm. A. Hammond, who, in the Guiteau trial, held that the prisoner was insane, yet should be hung. This view, however, is, I believe, held by a large part of every community. The homicide is usually dastardly, and the "crank" makes a certain show of reason and always spurns the idea that he is insane. These facts lead very generally to a popular and sometimes almost unanimous demand on the part of the public for his execution, some holding that he is sane or shamming insanity, others contending that his mental operations, while abnormal, did not prevent him from knowing the enormity of his crime and the difference between right and wrong. In short, the crime has been so revolting that the public does not wish to hear of arguments which will cheat them out of a victim to atone for the sacrifice of the slain. Both the men whose cases I have related knew right from wrong; both of them might have committed murder; and if they had, probably both would have admitted it was wrong and offered as excuse that it was necessary to protect themselves and families. What did the public gain by hanging the unfortunate paranoics Guiteau and Prendergast? Yet both these men, too, probably knew right from wrong. Happily this antiquated and unreasonable "right and wrong" test is, in the light of a higher and better medical jurisprudence, showing signs of decay. But it still shows great vigor. Hasten the day when it shall have disappeared altogether as a sufficient standard of sanity or insanity!

If the homicidal crank is not to be hung, what is to be done with him?

**RISK OF OPERATING WITHOUT CONSENT.**—An action involving a claim for £2000 (\$10,000) has been tried in Belgium, says the *Lancet*, which is of considerable interest to surgeons. It appears that a lady who suffered from uterine hemorrhage was recommended by a consultant who was called in by her family attendant to allow the uterus to be curetted, to which she and her husband consented. When the opera-

Certainly the public has the best right to demand protection from him.

This protection would be afforded by sending him to an asylum, there to remain until cured, or he might be sent for a certain term of years (10-15-20) and as much longer as might be required for his cure. Sent in either way, he should not again be set at liberty until after examination and unanimous recommendation for release by a competent board of physicians appointed for that purpose. If this plan were adopted rigidly, most "homicidal cranks" would remain incarcerated for life after having committed murder. For my own part I should like to see capital punishment abolished altogether. This done, the plan I have advocated would possess the further advantage that the plea of insanity would not be apt to be urged without cause when it was known that the defendant whether sane or insane would be incarcerated for life if it were shown that he actually committed homicide. In stating this I do not wish to be understood as saying that the plea of insanity is today unduly urged. Indeed I can endorse the position taken by Kiernan (*Alienist and Neurologist*, April, 1895, page 140), who in a very recent article says: "The enormous number of insane in penitentiaries proves that the plea of insanity, in place of being abused, is too rarely used."

Under the circumstances I have named attorneys would largely be relieved of the odium which now attaches to setting up the plea of insanity, with the certainty in almost every case of being accused by certain newspapers of setting up what they are pleased to call the "insanity dodge."

tion was begun it was discovered that there was cancer of the uterus, and the operator and the family physician decided then and there to remove the whole organ, the result being that the patient died from hemorrhage. As neither the patient nor the husband was consulted about the hysterectomy, it was held by the court to be unjustifiable. The damages were, however, reduced to £200 (\$1000).

**SOCIETY REPORTS.**

GYNECOLOGICAL  
AND OBSTETRICAL SOCIETY  
OF BALTIMORE.

MEETING HELD OCTOBER 8, 1895.

The 74th regular meeting of the Gynecological and Obstetrical Society of Baltimore was held October 8, 1895, the President, Dr. John Neff, in the chair.

*Dr. John Neff* read a paper upon EVIDENCE OF SEPSIS BEFORE ABORTION. (See page 21.)

*Dr. W. P. Chunn*: I do not remember to have seen a case where sepsis made its appearance before abortion. The arthritis in Dr. Neff's case was unusual. In a case recently seen, the first symptom of trouble after the abortion was high temperature.

*Dr. James M. Craighill*: I find that the early miscarriages are the ones that give the most trouble. Many times I am in doubt what to do with these cases.

*Dr. T. A. Ashby*: I am inclined to think that the case of arthritis was not sepsis. In all cases where the uterus is not completely emptied, I think there is but one thing to do—dilate and curette. I have curretted many such cases and have had no trouble from it.

*Dr. Wm. E. Moseley*: After many cases of abortion there will be a chill and fever that has no relation to the abortion. After abdominal operation there may be a phlebitis that is not associated with any local infection. We also often have a malarial infection. Use the finger, if possible, in emptying the uterus, because when the finger can be gotten inside the uterus a much more intelligent idea of the condition of the cavity can be formed. When this cannot be done dilate with the parallel bars and curette.

*Dr. William S. Gardner*: The case of arthritis related by Dr. Neff of course might have been due to some other cause than sepsis, but associated as it was with the abortion and the general condition of the patient, I think that it is highly probable that it was just such a joint infection as is seen in pyemia.

I have seen just such a case where not only the knees but other joints were involved.

I do not agree with the opinion that we ever have a phlebitis after labor or after abortion that is not associated with a local infection. I believe not only that we always have an infection but also that the infection takes place at the time of operation or labor, though it may not develop to a marked extent until several days have elapsed. I have never seen a case of this kind in which the patient had a perfectly normal temperature for twenty-four consecutive hours, between the labor or operation and outbreak of the septic attack.

*Dr. William S. Gardner* read the following paper: THE LESIONS ASSOCIATED WITH DYSMENORRHEA. (See page 19.)

*Dr. T. A. Ashby*: I agree with Dr. Gardner that dysmenorrhea is a symptom, and is due to a local lesion, and I believe that stenosis and anteflexion are responsible for a majority of the cases. It is confined largely to the sterile woman or the ones who have been infected. I have seen a few cases of fever and simple ovarian dysmenorrhea where it was necessary to remove the ovaries to cure the pain, but these cases are very rare. In cases where the ovaries were removed the corpora lutea were found to be the same as those of pregnancy. Ovariectomy should be the last resort.

*Dr. Wm. E. Moseley*: I believe that anteflexion is a much more common cause of painful menstruation than is commonly recognized. I agree with Dr. Ashby that it is the most common cause. The class of cases where you can make out the most direct cause is among the younger women. Dysmenorrhea associated with anteflexion is apt to be in women who are debilitated.

*Dr. Gardner*: These 120 cases of dysmenorrhea have been collected from about 1300 women with various complaints. In many cases the menstrual pain was secondary to some other more troublesome discomfort. My statistics certainly do not agree with Dr. Moseley and Dr. Ashby when they state that the majority of patients with dysmenorrhea

have anteflexion. Only a fraction over 13 per cent. of the cases which were examined had anteflexion. I think they have both been misled by depending upon their memories instead of upon their written statistics. Patients who suffer from dysmenorrhea due to anteflexion, as a rule, do not have pain at any other time, and this emphasizes that one symptom. While the larger number of patients suffering from dysmenorrhea due to other lesions have other pains and other complaints which mask the dysmenorrhea, I think this accounts for the patient's dysmenorrhea due to anteflexion being more distinctly remembered.

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#### ALLEGHENY COUNTY MEDICAL SOCIETY.

MEETING HELD AT PITTSBURG, PA.

*Dr. Theodore Diller* read a paper entitled THE HOMICIDAL CRANK. (See page 23).

*Judge Ewing*: I was well pleased to receive an invitation to attend this meeting tonight, from Dr. Hersman, but I supposed it was to give me an opportunity of hearing your opinions of the legal profession and of courts, rather than for me to express an opinion of the medical profession or of their beliefs. The doctors often learn in court what the lawyers think of them, and sometimes what the judges think of medical opinions; and I expected to hear an expression from the doctors, this evening, of their estimate of lawyers and judges, and have not been disappointed.

Now I did not come prepared to discuss this subject of insanity, with its bearing on legal responsibility. I came to learn something. The question is a very broad one. I have been greatly interested in the papers read, but I cannot, however, agree with many of the views advanced, and especially with regard to giving the disposal of criminal, especially of homicide, cases over to experts alone, or to take their testimony as conclusive. In my opinion this would be a very dangerous departure—the specialist and expert is so liable to become one-sided, whether he be a med-

ical expert, a patent expert, or whatever it may be. If I had a friend or relative whom I suspected was of somewhat unsound mind, or had some mental trouble, and I wanted to cure him, I would probably go to a specialist, an expert in that line of disease; but if I wished to be satisfied as to whether or not he was mentally sound, that is, sound enough to be morally and legally responsible for his acts, I would be disposed to go to the good old-fashioned "all-around" country doctor, who knows a little of everything.

I admit that frequently the medical man is not treated altogether fairly on the witness stand. He is frequently compelled to express an opinion upon a hypothetical question that does not cover the whole field of the particular case before the court; he has to be very cautious in his answers; he cannot frame the questions; the judges and lawyers control the questions. Unfortunately it often happens that lawyers are often retained in these cases who know little of medical science or anatomy or physiology.

But, to return to the doctors, allow me to make one suggestion in regard to them as witnesses. I think there are many who go on the stand rather more concerned as to how they shall acquit themselves, than with the case itself. The more completely a witness can lay aside that feeling, the better. The witness will then, likely, get along very well. Some witnesses always get along very well. I recall one of your number now deceased, who was an unusually good witness; always fair; he was a very valuable witness—I refer to the late Dr. James McCann, eminent in his profession, highly respected and esteemed by all who knew him.

I think in many cases of alleged insanity, the expert goes on the stand with a wrong impression of what he is there for. He is liable to think he is there to decide questions of law, and at times the expert witness would be of more assistance to judge and jury if that idea could be eliminated. This erroneous idea is also prominent in medical works. Two or three years ago, in

a case tried before me, the jury brought in a verdict of murder of the first degree. The verdict was against the testimony of the experts. I consulted a number of medical works on the subject of the particular phase of insanity from which it was alleged the defendant was suffering, to get more light on the subject, in order to satisfy my conscience and my judgment as to what I ought to do. From some of these books I received very little assistance. I found the same difficulty—in nearly all the books the writers seem determined to discuss and decide the law, rather than to give the facts or give the nature and effect of the disease in its different phases. That is not the province of the writer, but to confine himself to disease and its manifestations. I doubt if the expert in insanity is ever the most competent man to judge and decide what the law should be. In only two of about ten books which I consulted did I find anything of assistance to me. I remember one of them especially, given me by my friend sitting here (Dr. Chessrown), in which the author deemed it his province to lay down the law, about which he knew nothing. I had but little question as to the sanity of the author of that book—I have forgotten his name—I was satisfied he was insane, and I was not surprised later to be informed that he was one of the experts in the Guiteau trial. Please pardon me for taking so much of your time; as I remarked before, I came to hear, and not to speak.

*Judge Slagle:* I do not think I am able at the present moment without reflection to express views of any value upon this subject. There are one or two things, however, that struck me in the reading of these articles. The first was in Dr. Hersman's paper on the Ducoovic case. I think he misapprehends what the law is on the subject of insanity. The law books, as well as the medical books, say that delusion is insanity. It is not merely evidence of insanity. It is insanity. The question for the lawyers, the judges and the juries to decide is whether or not that insanity controls the man's will to such

an extent that he cannot resist it. If the insanity reaches that point, then responsibility ceases. If the perversion of mind governs the man's entire actions he is totally insane. But he may be sane on some subjects and perfectly insane on others, and if the act that is done is in the line of insane delusions, he is not responsible morally or civilly. When does responsibility cease? That is the question. As Judge Ewing states the doctors are to determine whether the man has an insane delusion, the facts and law of that insane delusion belong to the judge and the jury. We have the expert opinion to guide the jury, we have the judge to instruct them and to explain and apply the law, and I think that justice can be done as effectually in this manner as by a commission of experts. And this brings me to the consideration of a point in Dr. Diller's paper on the subject of cranks. The question in such case is, whether the man's peculiar ideas or sentiments constitute an insane delusion. If it is not an insane delusion, but merely a perversion of judgment, the man may be wicked, but he is not insane. Such cranks as Guiteau or Pendergast and the like do not come under any rule that exempts them from punishment for their crimes. Ask these men the reasons for their crime; ask that man Berkman. They will tell you that they are working for the good of society, that they do not care for themselves. We might say this is a crazy delusion, but these were wicked men rather than insane. Booth possibly thought he was doing his country service in killing Lincoln, but his mistaken judgment must not excuse his crime. I was very much interested in the articles read tonight. I think that the free discussion of such articles will be productive of much good. And I would recommend now as I have done before that lawyers and physicians should meet together and discuss such subjects. It would do both good.

*Charles A. O'Brien, Esq.:* It is not surprising to me that there should sometimes be good grounds for the old saying about doctors disagreeing. It is true

that they differ. It is often wonderful to me that there is not a greater divergence of opinion among medical men in some of the cases in our courts. And then again partisanship is a part of human nature. Partisanship exists and manifests itself in the legal profession, and we see it in the conduct of cases and in various other ways. And this is true also of the medical profession. Doctors may differ, often they do, and I do not consider it at all remarkable. Often there is good reason for conflict and difference of opinion by the most expert physicians as to what the disease really is. The physician in court is being appreciated more and more every day. He comes to the court room to aid, to help, and to assist in the investigation of truth. He is called now in a constantly increasing number of cases in which his testimony and his knowledge are needed. A number of physicians are becoming quite a familiar sight in the courthouse. So much the better. They come to help us. We need them. This meeting to-night is a manifestation of a spirit that is growing year by year in the medical profession, a spirit of liberality. You are advancing in the science of surgery and therapeutics, but you are also advancing further and further in the domain of human knowledge and education.

*Frank I. Gosser, Esq.:* I have noticed a feeling among medical gentlemen on and off the stand, a feeling of unrest and dissatisfaction arising from a consciousness that the members of their profession as expert witnesses are not accorded the consideration which they believe is their right, and I have heard considerable complaint on this score. The fact that their position, and their importance, and their learning have been minimized by the court, and that sufficient weight is not attached to their opinion as scientific men, are sources of dissatisfaction and annoyance. But I must coincide with the view of Judge Slagle. I do not think there has been anything advanced by the medical gentlemen to-night that would improve the administration of the criminal justice, although the articles were of great interest. The question of determining

the insanity of criminals by a commission is becoming to be a much mooted one. A commission of experts as an adjunct to the court in an advisory capacity might be an advantage, but I doubt the propriety of making the commission a tribunal. A commission of this kind might have been an advantage in the case of Frank Gerade, to which Judge Ewing referred. The accused was twice convicted of murder in the first degree, and the Judge not only was compelled to make extensive research among medical authorities, but in order to gain more insight into the case, he determined to observe the conduct and actions of the prisoner in every way possible, to be better able to come to a just determination as to insanity of the accused, or whether he was feigning, and thus by the vigilance and conscientiousness of a Judge the life of the accused was spared, and the administration of justice was exempted from the odium of having sanctioned the execution of a crazy man. As I said, in a case of this kind the assistance of an expert medical commission might be of advantage, but only as an adjunct, an accessory.

It has been said here to-night that Dr. Wm. A. Hammond, in the Guiteau case, expressed the belief that a crank under such circumstances should be hung, and exception has been taken to Dr. Hammond's stand. Insanity is a defense on the sole ground that it disables the accused from knowing if his act is wrong. The delusion must be a controlling one, it must have absolute dominion over the man's mental powers. If the delusion does not control and there remains such mental strength as to enable the man to perceive that he is doing wrong, it does seem to me that society demands protection, and may properly exact, in accordance with Dr. Hammond's view, the supreme penalty of the law, for these reasons :

First. The interests of society are paramount and must be protected. Simply by reason of the lack of precision in the science of the administration of criminal justice, it does not follow that the proposed innovation would render it more exact.

Second. Because the accused is not actually insane as long as he is able to discern the distinction and choose between a right and wrong act.

Because mistakes are made does not prove that the existing machinery of criminal justice is defective. If a shield were to protect all those who have or feign homicidal tendencies and exempt them from responsibility for their acts, there would be a vast increase in the ranks of the "Homicidal Crank." It unquestionably would mean substantial jeopardy to the lives and happiness of all our public men.

### CORRESPONDENCE.

#### THE THREE AND FOUR YEARS' COURSE.

BALTIMORE, October 22, 1895.

Editor MARYLAND MEDICAL JOURNAL:

Dear Sir: A report to the effect that the Baltimore Medical College is not living up to the requirements of the Association of American Medical Colleges having reached the ears of the Faculty, they deem it just to themselves to state publicly that this report is false.

Prior to the meeting of the College Association in Baltimore, the local schools opposed the four year obligatory course, but agreed to abide by the decision of the National Association, which was as follows :

"Candidates for the degree of M. D. in 1899 or thereafter shall have pursued the study of medicine for a period of four years and attended at least four courses of lectures of not less than six months' duration each."—Constitution and By-Laws of the Association of American Medical Colleges. Article III, Section IV.

From this it is evident that there is no reference to classes graduating in 1898, and each college was left to use its own discretion in matriculating such candidates. No agreement, verbal, written, or tacit, was made by the Baltimore Medical College with any other college, here or elsewhere, in regard to the class of 1898, and under these cir-

cumstances we matriculated men up to October 1, 1895, for a three years' course ending in 1898. Anyone who will consult the *Journal of the American Medical Association* for October 19, 1895, page 680, will find that the Judicial Council of the College Association has rendered the following decision in this matter referred to them (not by us, for we had no doubt as to our position) as follows :

Decision.—"It is the judgment of the Council that there is no rule of the College Association preventing any of the members matriculating students in September, 1895, and allowing them to graduate after taking three full courses of lectures of six months each, in three separate years, ending in 1898."

By no strain of the law can we be considered to have infringed on the decree of the Association and to claim that we have made any agreement with any Baltimore college beyond the demands of the Association is as false as it is absurd. Our policy is not to bandy epithets or to attempt by hard names to combat bad grammar and maliciousness, nor can anyone say that we have ever disparaged other schools to our students or insinuated that any sister institution could not carry out its contracts.

Students are free to select whatever school they choose as far as we are concerned, and we are content to gain their attendance by honest teaching and advanced facilities. We do not propose to change our policy in this regard, but to emphasize that anyone who says we are breaking faith with any college here, or the Association of American Medical Colleges, knows, if he be at all cognizant of the rulings of the Association, that he is speaking an untruth.

We are content to let this matter be decided by each one interested, provided he secure all the data on which to base his conclusions.

T. A. ASHBY, M. D.,  
J. D. BLAKE, M. D.,  
S. T. EARLE, M. D.,  
R. W. JOHNSON, M. D.,  
S. K. MERRICK, M. D.,  
DAVID STREETT, M. D.,

Committee of the Faculty of Baltimore Medical College.

MARYLAND

**Medical Journal.**

PUBLISHED WEEKLY.

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WASHINGTON OFFICE:

Room 22 Washington Loan and Trust Co. Building.

BALTIMORE, OCTOBER 26, 1895.

It is rare that a physician brings suit to collect his just fees and when he does take this step it is usually when **Physicians' Fees.** he has exhausted all other means, the right is on his side and injustice has clearly been done him.

The *Colorado Climatologist* contains an account of a suit brought by a physician against the estate of his patient. The bill was large, but the services rendered were exceptional, and the skill used great. Physicians brought to testify for both sides all agreed as to the validity of the charges, the court allowed him the fees with costs and this journal adds that the issue of this suit demonstrated the following three things:

1. That the charges made for professional services rendered take into account the financial status of the patient.
2. That no medical fee bill can circumscribe the charges of a physician; and finally—
3. That when unanimity of opinion exists

among physicians, the interests of the physician are best subserved.

If there is one thing that hurts a conscientious physician it is to receive during the attendance on a patient expressions of satisfaction and praise from the patient and family with demonstratious that such services can never be repaid and then at the end to have his bill disputed and this especially when the physician has exercised especial skill, has neglected other work and at the same time has seen the patient's slightest whim satisfied in the most luxurious way.

When the cure comes and the cost of that illness is counted, gratitude to the physician is forgotten and when his bill is presented then the payer, or rather the recipient of the bill, thinks it is a good time to exercise economy and while the patient is sent off with a nurse to some expensive resort to grow stronger, the responsible member of the family is left behind to reduce the doctor's bill to the lowest point possible.

The *Colorado Climatologist*, in commenting on the case cited at the beginning, says in conclusion :

If there is any one factor which tends to derogate the medical profession, it is the little value placed on medical services. The physician's services concern the living, and the value of life is inestimable. The rich man's life, computed as a commodity, is worth not only what he is willing, but what he is able, to pay for it, and when his willingness is not commensurable with his ability to pay, the physician is justified in demanding compensation proportionate to the business involved. It was a physician with commercial instincts who ventured a reply to the patient who told him that he "owed him his eternal gratitude." "You are mistaken," responded the physician, "you owe me exactly ten dollars." The *nach Belieben* of the German physician, or pay me what you can, has its more practical analogue in the custom of a surgeon in this city. His charges are made in accordance with the commercial ratings of individuals who apply to him for treatment. Until the physician conducts his business on business-like principles, he will never find relief for his affliction of chronic penury. A noticeable and pleasing feature of this suit was the unanimity of opinion expressed by the physicians on the subject of professional charges, and even the physicians called by

the defense were virtually experts for the plaintiff.

\* \* \*

It is astonishing to note the varied opinions, both lay and medical, held on the subject of the dangers of gonorrhea.

**Marriage and Gonorrhœa.** One physician will very justly give it all the gravity it deserves, while another will prescribe some simple astringent mixture and make light of the disease. Since the late Noeggerath traced so many obscure tubal and ovarian troubles in women to gonorrhœal infection from men, the disease has been looked at more seriously and the responsibilities of marriage between a man with an old gonorrhœa and a healthy woman have been most carefully weighed.

Dr. Ferdinand C. Valentine asks in the *American Medico-Surgical Bulletin* when may gonorrhœal patients be allowed to marry. He gives the subject the attention it deserves and cites a typical case according to which a man with an old and apparently cured gonorrhœa marries and infects a young, healthy girl. He suggests that these women should be protected and urges upon the medical profession not to make light of a gonorrhœa but teach their patients what a serious disease it is and what its dangers are. An apparent cure is so often not a real cure and what is called a second attack is only a relapse brought on by indiscretion before the original attack had entirely disappeared.

The disease may be cured as far as all external evidence is concerned and yet the presence of gonococci lying within the urethra may easily carry contagion. By the urethroscope the unhealthy mucous membrane, glands, crypts and follicles may be seen. It is suggested in a doubtful case to administer an irritant injection which will produce a flow lasting from one to two days. Then if this flow is found on examination to be free from gonococci, the ex-patient may be allowed to marry, but if any of these organisms are present, concealed, this injection will bring them to light and then the usual bacteriological methods will demonstrate them.

This irritant injection is not painful and even if it were, the author thinks it is far better than to let the wife suffer for years after marriage. The following propositions regarding gonorrhœa and marriage are thus summed up:—

1. Gonorrhœa, *per se*, is a dangerous disease, but curable at any stage;

2. Even when all external evidences of its existence have disappeared, the patient may still be able to infect;

3. A woman infected with gonorrhœa is in danger of her life;

4. No man should marry who can infect his wife;

5. In a week or ten days' time it can be determined whether a man can infect or not.

In view of the above it is manifestly the duty of every layman and physician to disseminate, as far as lies in his power, the knowledge that will save many a life. Physicians, in the exercise of their priesthood, are continually working against their own interests, by teaching the prevention of disease. Thus they fulfill their highest mission. The educated laity, many of whom are attending this Congress for the benefit of humanity, should aid our profession in this work.

It certainly is meet and proper to devise means for the protection of innocent babes. Is it not equally proper that innocent girls who marry to bear children to the man they love be protected? Their protection lies in educating men to abstain from marriage while they can infect. Every such marriage prevented will protect a woman from death, or what is far worse, a life of mental and physical torture.

\* \* \*

THE summer weather has passed away and with the cool, bracing air of autumn, physicians in common with many

**Renewed Activity.** others begin to work more seriously. To be sure, those to whose share fell the usual summer cases of diarrhea among the persons who remained in the city were occupied, but it is in the fall months only that the various medical schools begin work, the hospitals fill up with patients and the annual visitation of typhoid fever all bring the physician back to renewed activity, and if he has spent the summer resting and taking recreation he is much better able to cope with disease in his cases and himself escape sickness than his less fortunate but more ambitious colleague who has stayed home all the summer and now feels the tire and lassitude of one who has not taken a vacation. The one who boasts of never taking a holiday will soon wear out and regret this false economy.

**MEDICAL ITEMS.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending October 19, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		11
Pneumonia.....		18
Phthisis Pulmonalis.....		
Measles.....	24	
Whooping Cough.....	9	3
Pseudo-membranous { Croup and Diphtheria.	12	8
Mumps.....	1	
Scarlet fever.....	24	2
Varioloid.....		
Varicella.....		
Typhoid fever.....	26	9

Typhoid fever is very prevalent in and about Baltimore.

The first revision of Dr. Wm. Osler's "Practice of Medicine" is out.

It is said that forty thousand patients visited Carlsbad last year.

About \$2000 more is needed to ensure the publication of the *Index Medicus*.

The medical department of the Johns Hopkins University will issue a monthly beginning January 1, 1896.

The *Virginia Medical Monthly* will be issued as a semi-monthly and its pages enlarged, beginning in April, 1896.

Dr. Wm. H. Wathen, so long Dean of the Kentucky School of Medicine, has resigned his position on account of stress of work, and Dr. Sam E. Woody succeeds him.

The name of the *Texas Sanitarian* will be changed to the *Texas Medical News*. Drs. McLaughlin and Bennet, the editors, intend to make great improvements during the coming year.

The volume of the Transactions of the Medical and Chirurgical Faculty of Maryland for the past year has been completed and is in the hands of the Secretary, Dr. John S. Fulton, for distribution.

Dr. Pearson Chapman, a prominent physician of Perryman's, Harford County, Maryland, was married last week to Miss Frances

Michael of Michaelsville, sister of Dr. J. E. Michael of Baltimore.

The School Board of Baltimore City passed resolutions at its last regular meeting to arrange for the examination of the children's eyes by two oculists of Baltimore, who will give their services without pay.

The death is announced of Dr. Charles F. Cairnes of New Market, Md. Dr. Cairnes was the brother of Dr. George H. Cairnes, late supervisor of elections, and was graduated from the University of Maryland in 1874.

So many persons have become disgusted with the discount method of selling books that Messrs. P. Blakiston, Son & Co. of Philadelphia have determined to make all prices net, so that those persons at a distance shall pay the same price as those near by.

It has been decided by Dean Smith of the Yale Medical School that the lengthening of the course shall not take place this year, as was originally the plan, but will go into effect September, 1896. This fall's entering class will be the last to take a three-years' course; beginning with the class entering in 1896, a four years' course will be required.

The late meeting of the Medical Society of Virginia, held at Wytheville, Va., was a success. Many valuable papers were read and a good number of new Fellows were admitted to membership. Dr. William L. Robinson of Danville was elected President, and Dr. Geo. Ben. Johnston of that city First Vice-President. The next annual session will be held in Danville.

At the meeting of the Medical Examining Board of Virginia last September, the following schools were represented; College of Physicians and Surgeons, Baltimore, two applicants, one rejected; University of Maryland, one applicant, none rejected; Baltimore Medical College, two applicants, two rejected; Columbian University, Washington, two applicants, one rejected.

Baron Felix Hippolyte Larry, the distinguished French surgeon, died at Paris, October 8, at the age of eighty-seven years. During the Second Empire he was Surgeon to the French Emperor. A very interesting account of this wonderful man may be found in an excellent biographical article by Dr. Walter B. Platt of Baltimore, in the MARYLAND MEDICAL JOURNAL for June 16, 1894.

## PUBLIC SERVICE.

OFFICIAL LIST OF CHANGES IN THE STATIONS  
AND DUTIES OF MEDICAL OFFICERS.

## UNITED STATES ARMY.

*Week ending October 21, 1895.*

The extension of leave of absence on surgeon's certificate of disability, granted Captain James E. Pitcher, Assistant Surgeon, is still further extended two months on account of sickness.

Leave of absence for one month, to take effect about November 10, 1895, with permission to apply to the Adjutant General of the Army for an extension of one month, is granted First Lieutenant John S. Kulf, Assistant Surgeon U. S. Army.

Leave of absence for thirty days is granted Major B. F. Popper, Surgeon U. S. Army.

Captain Julian M. Cabell, Assistant Surgeon, ordered to David's Island, New York, for duty, in lieu of reporting to the Surgeon-General for duty.

Major Henry M. Cronkhite, Surgeon, having been found incapacitated for active service, is retired, to date from September 17, 1895.

Major William E. Waters, Surgeon, to be Deputy Surgeon-General with rank of Lieutenant Colonel, October 1, 1895, Vice Billings, retired.

Captain Louis S. Tesson, Assistant Surgeon, to be Surgeon with the rank of Major, September 26, 1895, Vice Matthews, retired.

Captain Edwin F. Gardner, Assistant Surgeon, to be Surgeon, with the rank of Major, October 1, 1895, Vice Waters, promoted.

Leave of absence for one month on surgeon's certificate of disability, with permission to leave the limits of the department, is granted First Lieutenant Isaac P. Ware, Assistant Surgeon.

## BOOK REVIEWS.

**MODERN MEDICINE AND HOMEOPATHY.** Two Addresses by John B. Roberts, A. M., M. D. The Edwards and Docker Company. Philadelphia. 1895.

The author of these two presidential addresses has devoted himself for several years to the study of homeopathic literature in order that he might divest himself of all prejudice against it. The result of his studies is here published "in the hope that some members of the medical profession may find in them reasons for abandoning a sectarian name, and that others may see the impropriety and folly of proscribing those whose opinions conflict with their own." This is the best brief expo-

sition of homeopathy that we have seen and it is adapted for non-professional as well as professional readers. The author divides homeopaths into two classes; those who strictly adhere to Hahnemann's teachings and those who have abandoned all but the name and a professed, though not an exclusive, belief in the doctrine of similars. By their own showing the former do not in all the world exceed 300. Rejecting these on account of the ridiculous absurdities of their doctrines and practice (so often described and so well known) he declares that the other class should not, if otherwise qualified, be excluded from professional intercourse with us and from membership in our societies. He shows by quotations from their own literature that their education and beliefs are similar to our own. He adduces the fact that they are eligible to membership in the American Medical Association, that the New York Medical Society permits its members to consult with them, that the Association of American Medical Colleges recognizes the instruction given in their schools as adequate by admitting their students to advanced standing in regular colleges and one school, the Woman's Medical School of the Northwestern University of Chicago, admits their graduates to its senior class equally with the graduates of non-sectarian colleges. These things show that professional sentiment is veering strongly in the direction the author would have it go. As he intimates, the revenue derived from a profession of homeopathy is a great stumbling block to this desirable consummation. These lectures should be widely read, as they cannot fail to do good, throwing light in a calm, dispassionate way into places which need it badly.

## REPRINTS, ETC., RECEIVED.

**Flooding the Urinary Tract.** By B. H. Daggett, M. D., Buffalo. Reprint from the *Buffalo Medical Journal*.

**The Dilator in Diseases of the Air Passages and the Ear.** By S. S. Bishop, M. D., Chicago. Reprint from the *National Popular Review*.

**A Case of Delphic Uterus with Lateral Hematocolpos, Hematometra and Hematosalpinx.** By X. O. Werder, M. D., Pittsburgh. Reprint from the *Journal of the American Medical Association*.

**CURRENT EDITORIAL COMMENT.****THE MEASURE OF RESISTANCE.**  
*Medical Brief.*

THE law of constitution is impassable. There is a best for each individual beyond which he can not go. To recognize this law is the touch-stone of a physician's ability. It will be the guiding spirit of his treatment, and lay a benediction upon his patient's life.

**CHARITY PRESCRIPTIONS.**

*American Druggist and Pharmaceutical Record.*

A WAY has been found effective and economical, even in large cities, in the case of private hospitals and institutions, viz.: Letting out of contracts to certain druggists of the town, who are paid a fixed sum by the institution making the contract, on the understanding that they will supply medicines on prescriptions to poor patients at a uniform price of 10 cents for each prescription; and where expensive remedies are ordered the drugs are supplied at cost. A few of the endowed hospitals and dispensaries of New York City have adopted this system and find it an economical method of furnishing the sick poor with medicine.

**THE LAITY AND MEDICINE.**

*Columbus Medical Journal.*

THE question of educating the laity on medical and surgical subjects is one with two sides. An ancient writer has said: "A little learning is a dangerous thing." The idea set forth a few years ago that the physician should keep the patient enshrouded in mystery as to the science and practice of his art is fast becoming obsolete. The increased education of the masses, the result of free schools in a free republic, has done much to set aside this idea, which we will concede was a necessity with our forefathers, who practiced largely among ignorant patients, whose education was not sufficient to enable them to comprehend any extended explanations regarding the method of treatment employed. The tendency at present is for the pendulum to swing too far the other way. While we believe that intelligent patients should receive a brief, comprehensive explanation regarding the nature of their disease, and the reasons for a certain line of treatment or an operation, we also believe that it is detrimental to both patient and physician to go into details.

**PUBLISHERS' DEPARTMENT.**

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

The safest mode of remittance is by bank check or postal money order, drawn to the order of the *Maryland Medical Journal*; or by Registered letter. The receipt of all money is immediately acknowledged.

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Physicians when communicating with advertisers concerning their articles will confer a favor by mentioning this Journal.

Address:

MARYLAND MEDICAL JOURNAL,  
209 Park Avenue, Baltimore, Md.

**NOTES.**

SENNNA is used in the incontinence of urine of locomotor ataxia.

\*

MORPHINE and hydrocyanic acid or cyanide of potash are incompatible.

\*

TUSSOL is the name given to a compound of amygdalic acid and antipyrine.

\*

PROFESSOR V. ZIEMSEN says that strophanthine is not cumulative in its action.

\*

FOR constipation of infants, perform massage of the bowels two or three times daily.

\*

IN supra-orbital neuralgia, applications of campho-lyptus will usually afford prompt relief.

\*

HOT water in teaspoonful doses is a very effective remedy in persistent paroxysmal cough.

\*

A SMALL quantity of washing soda added to sterilizing solution will prevent the rusting of instruments.

\*

IN tumefaction of the breasts, arsenic iodide, one-twentieth grain three times daily, will afford relief.

\*

DR. H. LANGES speaks highly of treating varicose ulcers of the legs with an ointment of the red oxide of mercury.

\*

IN almost all cases of septic intoxication, we will have an enlargement of the spleen, and we may also have an accompanying enlargement of various lymphatic glands.

# MARYLAND MEDICAL JOURNAL

A Weekly Journal of Medicine and Surgery.

VOL. XXXIV.—No. 3. BALTIMORE, NOVEMBER 2, 1895. WHOLE No. 762

## ORIGINAL ARTICLES.

### REMARKS ON GOITER, WITH REPORT OF CURES.

READ BEFORE THE RICHMOND ACADEMY OF MEDICINE AND SURGERY.

By Joseph A. White, A. M., M. D.,

Professor of Ophthalmology and Associate Professor of Otology and Laryngology, University College of Medicine, Richmond, Va.

JOHN BEATTIE, aged 46, a stonecutter by trade, consulted me in December, 1894, about his eyes. I prescribed the needed glasses and noticed he had a very large goiter which I took to be a fibro-cystic enlargement of the thyroid gland, from a very cursory examination. There were several cysts, one in the right and two in the left lobe of the gland. I asked why he did not have it treated and his reply was that he was so discouraged by the failures in the past, he had given up; although it was steadily increasing in size. It had begun about fifteen years previously, as far as he could recollect, and for over twelve years had been a marked deformity. He had tried iodine injections, tapping sac with an aspirator, the constant current and, as he expressed it, the "electric needle."

On June 27, 1895, he returned and asked me what could be done with the goiter, as it was becoming an impediment to respiration because of compression of the windpipe. Having had very satisfactory results with iodide of potassium by cataphoresis in goitrous cases, I commenced treatment with this plan. Up to Wednesday, July 17, I had used cataphoresis twelve times, with some slight diminution of the tumor and improvement to respiration. On July 17,

I opened the central cyst at the bottom and drained off a quantity of dark-brownish, muddy fluid, similar to what is seen in ovarian cysts, etc. The sac was washed out until the returning liquid was clear and a small quantity of iodine injected. The opening was kept free by packing with gauze. For several days the sac was washed out and packed daily, with considerable improvement.

On July 27, I cut into the left cyst from the top and passed the knife across and out at the opening made in the lower part of the central cyst, which was followed by a discharge of the same fluid and venous hemorrhage. Iodine was injected and a silver drainage wire was inserted, entering one opening and out through the other; antiseptic gauze was packed into the cyst. The next day he was unable to come to my office, being confined to bed. He was visited twice daily and the sac was washed out with peroxide of hydrogen and bichloride of mercury.

On the 31st, his neck was enormously swelled, especially on the right side, all the lymphatics being involved, and deglutition was almost entirely arrested. I at once cut into the right cyst and drew off a great quantity of fluid. This sac was connected with the others and a drainage wire, with packing, inserted.

Every day the sacs were washed out, disinfected and packed. Quinine and stimulants were used internally. On August 4 his temperature rose to 104°, pulse 126; and on the 5th and 6th, 101°; and in a few days, normal. He was put on iodide of potash, which was increased to 60 grains three times a day. By September his neck was reduced almost to its normal size. Some little thickening of the parenchyma of the gland remained, although the cyst had entirely disappeared. For this, cataphoresis was continued and you saw his condition two weeks ago, when he presented himself to this Academy. From wearing a 17-inch collar, he was wearing a 14½-inch. The contour of the neck was perfectly natural. The thyroid cartilage was prominently defined and, with the exception of the scars of the incision, there was little or no sign of trouble of the thyroid gland.

The above case is an interesting one in its results and on account of the prominence which the thyroid gland has assumed in medical journals the last year or so, especially in relation to the use of the extract of the thyroid glands of animals in the treatment of myxedema; although the subject of goiter itself seems to have received but little attention. I find, in looking over the medical journals of the last year or so, that very little is said in relation to this matter; most references to the thyroid gland being in connection with the treatment of myxedema. Goiter, however, whilst receiving but a short chapter in most text-books on surgery, is a subject of considerable importance. We have different troubles of the thyroid gland, such as acute thyroiditis; bronchocele, or goiter of different forms, such as follicular, fibrous, fibro-cystic and cystic; and that peculiar complex of symptoms known as exophthalmic goiter.

I have no doubt that the reason that we only occasionally find writings upon this subject in the regular medical journals is due to the lack of knowledge of the functions of the thyroid gland and the difficulty of explaining etiologically the various changes that take place.

Some recent investigations into the functions of the gland by Hurthle, Eulenbergh and others, may result in a better understanding of the pathological alterations. Hurthle reports that the colloid substance in the follicles is produced by the protoplasm in the epithelial cells and that the secretion of the gland consists in the formation of this colloid substance. It is supposed that pathological changes in the gland are due to some deterioration of this normal secretion. Probably some evidence of this is found in the fact that the same treatment (the use of thyroid extract, for example) decreases the enlarged gland and improves the bad results which come from the absence of it, such as myxedema. Another corroboration, probably, is the well known fact that cretinism is found in connection with both hypertrophy and atrophy of the gland.

Eulenbergh thinks that the constitutional symptoms of exophthalmic goiter may be the direct toxic effects of absorption into the veins of the increased altered secretion of the follicles, which produces chemical changes in the constitution of the blood. If this theory is correct, the nervous origin of exophthalmic goiter must be discarded. That it is tenable is shown by the fact that nearly the same symptoms are produced by the artificial introduction of thyroid secretion in excess. But these theories in regard to the etiology of the pathological changes of the thyroid gland are somewhat speculative as yet and require further investigation and confirmation.

The treatment of troubles of the thyroid has received lately considerable impetus. We might divide it into medical, electrical and operative.

*Medical.*—The medical treatment is by the internal administration of suggested remedies, such as iodide of potash, fluoric acid, thyroid extract, etc., and locally, by the introduction in the substance of the gland of iodine, iodoform, etc. Everyone is familiar with the iodine treatment. It is the oldest and has held its ground longer than any other, with varying success. Probably 90 per cent. of follicular and fibro-cystic

goiters are reduced in volume by this treatment, but few radical cures are recorded. Garé of Tübingen reports, however, very great success with the injection of iodoform, one part to seven of oil and ether. Kocher of Berne has used thyroid extract in twelve cases, all of which were improved, some cured. Bruns of Tübingen also tried feeding in twelve cases with fresh calf thyroid. Four or five cases were cured, and the others, with the exception of three, much improved.

*Electrical.*—Under this heading I would include three methods of using electricity. First, galvanizing, by passing the continuous current through the gland, both poles being on the tumor; second, by electrolysis; and third, by cataphoresis. With the use of the constant current I have had little or no experience. It has been suggested for the reduction of the different kinds of glandular enlargements and has been used with varying success. Electrolysis I have used in follicular and fibrous goiter. The negative pole is generally passed into the growth and a current of ten milliampères is turned on and continued for about five or ten minutes. This can be repeated in from three days to a week, according to the amount of irritation set up, the strength of the current being increased until we can use as much as forty or fifty milliampères. Gradually a reduction of the growth takes place under this treatment and a number of cures are recorded as its result. It is of very little service, however, in cystic goiter, because we cannot get the effect of the negative pole in the alteration of the tissue of the growth as we do in the more solid tumors. It has been suggested to tap the cyst, wash it out, fill it to distension with chloride of sodium solution, and by this means receive the full effects. With electrolysis from four or five to a dozen or more sittings are required.

*Cataphoresis.*—The third method, that of cataphoresis or the introduction of remedies by the direction of the electric current, has been in my hands a very satisfactory treatment, particularly in follicular goiter. I can record two or

three cases in the last eighteen months where I have had the most satisfactory results from the use of iodide of potash by this method. I use, attached to the positive pole, a metal disc, which is covered with wet chamois or cotton, upon which is packed as much powdered iodide of potash as it will hold. This is covered over with a thin pledget of wet cotton and applied to the growth. The negative pole is held in the hand, or applied to the back of the neck, or between the shoulder blades. I have seen very little notice of this method of treatment. The only case that I know of recorded was one reported by Dr. McGuire two or three years ago, in the *Virginia Medical Monthly*.

In the goitrous enlargement or bronchocele, which one observes in young people, young girls especially, about the time of puberty, I do not know any more satisfactory treatment. It is true that this form of bronchocele occasionally manifests itself only at the time, or during the period of menstruation and very frequently gets well of itself. I am not, however, referring to this form, but to those cases of persistent enlargement of the gland, which not only is seen during the menstrual period, but is present more or less all the time until active measures are instituted for its relief. I have seen cases of follicular bronchocele that have become very large in women because no attention was paid to it in the stage where it would swell up and go down, as it were, on the theory that it would get well of itself. One of these was very large, and persisted for several years, and was cured by the application of iodide of potash by cataphoresis. This case I have already mentioned, and it is one known to most of you. I am satisfied that further investigation into this method of applying remedies will show it to be of great value. In regard to operation, I am satisfied that in cutting open the cysts, as I did in the case above recorded, that I was exposing this patient to as great danger as if I had removed part of the gland. This was evidenced by the symptoms that developed.

Partial thyroidectomy, or strumec-

tomy, as some call it, is recommended by many authors for follicular and fibrous goiter. Strom of Christiania has reported quite a number of operations with success. He also advises enucleation of the cyst for cystic goiter.

Morris, in the *Lancet*, January 5, 1895, reports two cases of multiple cyst of the thyroid gland, such as the case before reported, in which he also practiced incision with satisfactory success.

Marsh, in the *Birmingham Medical Review*, reports five cases of bronchocele operated on for urgent pressure symptoms (all the cases being of comparatively short duration), in which he had good results, and he advises removal of the isthmus and as much of the lateral lobes as may be needed to relieve pressure, which is followed by atrophy of the rest of the gland.

Brooks reports two cases of partial thyroidectomy followed by success.

Operation has also been suggested and performed by quite a number of authors for exophthalmic goiter on the ground that it is a hyperplasia of the gland structure, and that the nervous symptoms are due to the toxic effects of the altered secretions, and a number of cures are reported. Greenfield's article in the *British Medical Journal*,

December, 1893, is probably the best of these contributions. All operators, however, have come to one conclusion, that complete removal of the gland is unjustifiable, and that all operations are more or less dangerous, death on the table having resulted in a number of cases from collapse. It is doubtful that any deaths have resulted from hemorrhage, although in some cases the bleeding is hard to control because of the difficulty of applying ligatures to the vessels, whose walls are in such a condition that ligatures will tear loose. To arrest the bleeding by packing is not satisfactory and may be dangerous. I have no doubt that during operations on the thyroid gland some of the fatal results were due to prolonged pressure on the pneumogastric nerve. If proper care is taken in performing the operation, the bleeding arrested as the operation proceeds, and the field kept as aseptic as possible, I believe the operation of partial thyroidectomy would be comparatively safe. Care must also be taken not to injure the recurrent laryngeal nerve. This operation has been successful in a great many instances, but there have been some failures, as is the case with all operations in surgery.

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**INTRACRANIAL NEURECTOMY.**—Dr. Dandridge (*Boston Medical and Surgical Journal*) states that to the nineteen cases of Rose's operation reported by Keen there are four additional ones to be added: (Eskridge two, Andrews one, Dandridge one), with one death, or twenty-three cases with three deaths. Andrews reports a case of death from brain disease one month after operation; if this be charged to the operation we have twenty-three cases and four deaths. To the Hartley operation there are seven additional cases: Richardson one, Keen two, Parkhill one, Rose one, and Tiffany two, with three deaths (Keen, Parkhill, Rose). This gives, with Keen's nineteen reported cases, twenty-six cases and five deaths.

The result thus far obtained in the intracranial operations do not justify

the abandonment of the more superficial neurectomies in persistent neuralgia, but certainly justify the expectation that they will afford great and possibly permanent relief where recurrence takes place—a relief so great as to fully justify the danger they involve.

\* \* \*

**PLACENTAL CIRCULATION AND MORPHINOMANIA.**—Bureau (*British Medical Journal*) attended a patient who had taken morphine for seven years, and who when he saw her took as much as fifteen grains of that alkaloid daily. She was pregnant for the fourth time. At length she was spontaneously delivered of a child with talipes of one foot. As the cord was divided Bureau collected the blood of the placenta and umbilical vessels. On chemical analysis morphine was detected in the blood.

## AUTO-INTOXICATION.

READ BEFORE THE ALLEGHENY COUNTY MEDICAL SOCIETY.

*By G. B. Sweeny, M. D.,  
Pittsburg, Pa.*

AUTO-INFECTIOIN, intoxication, and other terms, are applied to those conditions when the human organism, to a greater or less degree, becomes poisoned by products which have been elaborated within the economy.

That such infection does take place, under certain circumstances, has been admitted by physicians from time immemorial; at the same time, the exceeding scarcity of literature bearing upon this subject suggests only too strongly how little of definite knowledge has been gained. What information has been gained has been obtained under circumstances which render it very difficult to demonstrate beyond a doubt many phenomena which we believe are due to auto-infection, and which we are daily combating successfully by administering remedies which clinical experience proves are antagonistic to the morbid elements at work in the system.

The chemical changes which are constantly taking place within the body in both physiological and pathological conditions, and which cannot be satisfactorily studied in detail outside the organism, compel us to admit that, after all, nature works largely behind closed doors, and must form at least a part of our apology for failing to satisfactorily answer some questions which naturally would suggest themselves in considering this subject, and which, in the light of rapid advancement in other lines, would seem to demand solution.

Our work in this field of investigation must be done largely in an inductive manner. Taking phenomena we must discover and identify causes. Incidentally, permit me to say that the crowning glory of the nineteenth century, from a medical standpoint, is the disposition to study the origin of disease. A new and beneficent era of progress in the science of medicine must be ushered in through

the untiring and zealous efforts of an army of earnest workers who are identifying processes, physiological and pathological, and discovering the places where they diverge, and pointing out the causes of disease.

Going immediately to the question of the causes of disease we recognize four primary pathogenic processes. The first of these, elementary dystrophies, while arising from vital activity of cells when acted upon by some external causes, physical, mechanical or chemical, is especially difficult to study, as the simple process is usually complicated by effects of a local character.

The second of these causes, nerve reaction, is also difficult to assign to its proper place in the production of disease. We may well pause and consider whether we have accorded to the reflexes more or less pathogenic influences than they actually exert. Certain it is that they usually play a secondary role in the subjects previously reduced by other influences. The two other pathogenic processes are disturbances interfering with nutrition and infection.

Bearing directly upon the first of these is the question of diathesis, which has been aptly defined as a permanent disturbance of nutrition, which prepares, provokes and maintains different diseases as seen in their location, their evolution and pathological processes.

Infection is the last of the four pathological processes. Traces of this nature are found far back in the history of medicine, but it has remained for these latter days, after witnessing discoveries brilliant and dazzling, although not always absolutely accurate, to demonstrate that in the body of an individual attacked by a contagious disease there exist lower vegetable organisms, capable of implanting themselves and multiplying in the tissues of a healthy man, and

of causing in him a disease similar to the original.

To speak of the specific microbe instead of virus, or of contagion, is not to supplant one idea by another; it is to advance from the vague and indefinite to the definite and rational.

This inquiry naturally presents itself to our minds: What makes possible the development of disease? It is not the chance meeting of man and microbe. This meeting is constant, generally unattended by results. Infectious disease is only an accident because the infectious agent finds only exceptional circumstances favorable, not to its penetration, but to its development and multiplication. In health man is not attractive to the microbe, but when his vitality is weakened then his means of defense are diminished.

The chemical constitution is modified by disordered nutrition and invites the invasion of the microbe. Persons fatigued by overwork, exposed to depressing influences, are struck by conditions real and disease developing from insignificant nerve excitations which would have produced nothing in perfectly healthy men.

The reaction of a disturbed nervous system induces temporary disturbances of nutrition. This in its turn opens the way to infection always at hand, to germs always present which certainly have to fulfill in nature another part, but which destined to destroy dead matter, are also capable of destroying living matter when they find it in a state of preparation. Here lies, perhaps, the history of angina, rheumatism and pneumonia. When the physician shall be in possession of this double knowledge that many diseases are produced by the microbe, and that these can act only by

a deterioration of the health, resulting from various pathogenic processes, he will recognize that the new discoveries contain nothing subversive, and that the lesson taught by ancient medical observations are not compromised. He will know that whilst seeking the means of combating microbes he ought, and he will always be obliged to sustain the forces of the organism and make good its defense, inspiring himself constantly with this truth: Before every illness there is a disturbance in life—for nutrition is life. Perverted nutrition leads up to the development of new substances which may become toxic.

We find in the organism peptones, which do not originate in the intestinal tubes, but which are injurious in this sense, that being dialysable, they escape by the urine, and thus bring about abnormal spoliation of the organism. Herein is intoxication.

But infectious agents can produce something injurious, can elaborate substances that are toxic. We find a great many bodies produced by the life of the microbe. They form soluble ferments which produce local lesions by breaking up living cells. It is certain that intoxication arises in part from the harmful action of microbes which, seeking a vulnerable point in the economy, proceed to a deleterious work.

As is well known, the kidneys and the alimentary tract are the highways in which these morbid processes usually have their origin.

To elaborate upon the different ways in which these processes manifest themselves is beyond the range of this paper, as I have only hoped to introduce this very important subject, which I am sure must be one of deep interest to this intelligent body.

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LOSOPHAN IN DERMATOLOGY.—Dr. J. Abbot Cantrell (*Therapeutic Gazette*) has used losophan in solution, in powder and in ointment in treating certain skin troubles and from his experience has given the following summary:

1. It proved entirely ineffectual in almost every disease of the skin.

2. Tinea sycosis was cured in one instance, but after two months' treatment.

3. It gave a slight idea that it may be beneficial in acne.

4. I think it a waste of time for any one to make use of it in treating diseases of the skin.

## CANCER OF THE STOMACH AND OTHER CASES.

READ BEFORE THE ALLEGHENY COUNTY MEDICAL SOCIETY.

By R. W. Stewart, M. D.,  
Pittsburg, Pa.

I HERE exhibit to the members of the Society a specimen of a cancer of the pyloric end of the stomach for which, on June 5, at the Mercy Hospital, I performed gastro-duodenostomy, using for the purpose a Murphy button. At the time of the operation, the patient's weakened condition precluded a pylorectomy. After the operation the patient rallied well; in one week he was eating solid food, and on the thirteenth day passed the button. Soon afterward he was discharged from the hospital. On July 20, the patient died, and his family physician, Dr. Stein, removed the specimen, which shows almost complete occlusion of the pylorus at the point of anastomosis. The most important point, however, is the marked diminution in the caliber of the anastomotic opening as compared with the size of the original button. Even if we take into consideration the shrinkage attributable to the immersion of the specimen in alcohol, it must be still admitted that there has been considerable shrinkage of the opening, a fact which seriously militates against the usefulness of the button. It should be added, however, that in this case a prolonged operation would have been out of the question, and I am satisfied that the button anastomosis was, under the circumstances, the proper procedure to adopt.

This is a patient suffering from gliosarcoma, for which I have operated three times. On April 15, the patient had a convulsion. At irregular periods following this the convulsion was repeated. On June 4, he was admitted to the Mercy Hospital. At this time there

was loss of speech, paralysis of the right arm and lower part of the right side of the face; frontal headache was marked; convulsions daily, usually unaccompanied with loss of consciousness and limited to the paralyzed area. Dr. Robeson examined the eyes and reported that the eye-grounds were in normal condition. On June 17, an osteoplasty of the skull was made, and a half ounce of sarcomatous material was removed from the brain over Broca's convolution. Recovery was prompt and the result, as far as the paralysis is concerned, was perfect, with the exception of a slight paresis of the lower part of the face. The convulsions, however, persisted and on this account a second operation was performed on July 25, and about a drachm of diseased brain tissue removed, which was submitted to microscopical examination by Dr. Wasdin, who reported it a glio-sarcoma. The patient's recovery from this operation was as good as on the first occasion. On August 10, he had, however, a severe convulsion in which he was unconscious, and it was followed by a delirious attack lasting over an hour. After this, headache became severe and constant; the pulse dropped to forty-five, indicating increased intra-cranial pressure. On August 14, I again operated, removing one ounce of the diseased brain tissue. At the present time, six days after the operation, there has been no return of the convulsions, but the right arm is paralyzed. A slight hernia cerebri has developed, which in this case seems a fortunate occurrence.

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CASEIN IN WOMAN'S MILK.—Wróblewski (*British Medical Journal*) has made researches into the comparative properties of casein in woman's and casein in cow's milk. The casein is different in the two kinds of milk. In woman

it contains less carbon, nitrogen, and phosphorus, but more hydrogen and sulphur. The solubility of the casein differs, and different chemical changes go on when cow's or woman's casein is submitted to gastric digestion.

**SOCIETY REPORTS.****RICHMOND ACADEMY  
OF MEDICINE AND SURGERY.**

*Dr. Joseph A. White* read a paper entitled **REMARKS ON GOITER, WITH REPORT OF CASES.** (See page 37.)

*Dr. Charles M. Shields* remarked that up to five or six years ago he had been treating goiter with electrolysis by the labile method, a pole on either side of the tumor. In two cases a cure was permanent. Three-quarters of the cases in girls occur at puberty and as these cases get well anyway, it is doubtful that the cure was the result of electrolysis. For the last four or five years, he has been treating goiter by cataphoresis as described by Dr. White. In three cases, the results were good. In the first case, the neck was reduced one and one-half inches to normal. In the second, there was marked improvement, but reduction was not complete. The third had been treated previously and reduced one and one-half inches. Under Dr. Shields' treatment, reduction was permanent. Another case was that of a young Italian affected by goiter for eight years. He had been treated in Italy by injection and electrolyses. The growth was cystic and looked suppurative. Counter puncture was done and the tumor washed out every other day with peroxide of hydrogen. It was larger than a hen's egg, but now there is no perceptible enlargement. Results, as a whole, however, are such as never to make him promise permanent cure.

*Dr. Jacob Michaux* said that in doing a tracheotomy in a child with diphtheria, he was obliged to go through the isthmus of the thyroid gland; and the amount of hemorrhage ensuing made him fear greatly for the safety of the child.

*Dr. W. W. Parker* never fails to stop goiter in the formative stage, by a blister applied every ten days.

*Dr. J. W. Henson* spoke of the operation of opening the deep fascia and stitching it to the integument.

*Dr. White*, in closing the discussion,

stated that he had listened to the remarks with interest; that he had only known the evening before that he was to be called on to open the discussion on goiter; and that he regretted the brevity and necessary incompleteness of his remarks, limited as they were mainly to his own experiences and his recollections of what others had said and written in relation to bronchocele; but that he would try to reply to the gentlemen who had spoken on the subject he had introduced.

In regard to Dr. Michaux's remarks as to the dangers from cutting through the isthmus, he had learned from his experience that this was one of the traditions in the profession used to scare timid operators, like the nursery ghost stories to quiet refractory children. He had often, in doing tracheotomy in a hurry, to open the trachea without regarding the isthmus; and whilst he had seen considerable bleeding, which usually stopped on inserting the tube, he had never seen a dangerous hemorrhage. Once he was called at midnight to a man who had been apparently suffocated by the pressure of an enormous goiter, and was obliged to open the trachea by candle light as quickly as possible. Dr. O'Brien of Alexandria assisted him on that occasion and he cut directly through the center of a fibrous goiter three inches thick, without regard to hemorrhage, until he reached the trachea, which was opened; and the man was resuscitated by artificial respiration. Even then the hemorrhage, whilst considerable, was not dangerous in amount.

He was glad to know that Dr. Shields' experience with the cataphoretic action of electricity had been favorable, but did not think it necessary to put the remedy on both poles, as the positive pole was the active agent in inducing the remedies into the tissues. He thought also that Dr. Shields' idea of electrolysis was rather different from the common acceptance of that term, inasmuch as he seemed to confound the passage of the *constant current* or galvanism, through the growth, with the destructive action of the negative pole introduced directly into the tumor, the

term *electrolysis* referring only to the latter.

Dr. Parker's experience with goiter was more favorable than his own; especially in the lucky circumstances that he always saw them just in their incipiency when counter-irritation with blisters was sufficient to cure. All the goiters he had ever seen were well-developed tumors of long standing when the case applied to him. On one occasion, however, he had seen an enlargement of the thyroid cured by a blister. It was a case of non-suppurative thyroiditis, the only one he ever saw, which developed so rapidly in a very short time as to threaten suffocation. He at once applied an ointment of red iodide of mercury and iodide of potash all over the front of the neck, producing an enormous blister and in a few hours promptly relieving the patient. Meanwhile, he sat by, expecting at any time to be obliged to open the trachea.

Dr. Henson was quite right in saying he had seen report of merely opening the deep fascia in goiter, as it was an operation suggested to relieve dyspnea from pressure of the glands on the trachea, but Dr. White had never seen a case of cure recorded, from this method, although it was quite within the bounds of probability that after relieving the pressure of the fascia upon the gland, atrophy of the gland might have ensued and therefore it is not at all improbable that he had seen a report of a case cured by this operation, although it was performed merely for the relief of suffocative symptoms and not to cure the goiter.

MARK W. PEYSER, M. D.,  
Secretary.

## CORRESPONDENCE.

### THE THREE OR FOUR YEARS' COURSE.

Editor MARYLAND MEDICAL JOURNAL:

*Dear Sir:*—Allow me to call attention to the communication of the Baltimore Medical School, in your JOURNAL, of October 26, in order that I may speak briefly upon its statement that: "By no strain of the law can we be considered

to have infringed on the decree of the Association."

It is true that in California in 1894 the Association of American Medical Colleges passed a resolution extending the curriculum to four years. It is true that at that meeting and by all readers of its transactions it was understood that with the session of 1895 was to begin the four years' term. It is true that at the session of the Association of Medical Colleges which met in Baltimore in 1895, when this resolution was reaffirmed, not one word was said by any delegate implying a different understanding as to the time when the four years' session was to begin.

It is the firm conviction of the writer that not one delegate then believed it to mean anything else. It is my firm conviction that those who subsequently found the language of the law susceptible of a different interpretation availed themselves of its unfortunate language with the full and clear understanding that they were violating the spirit of the law.

Having from the first entertained these opinions, I said as much and am willing to submit them to the profession and to the Association of Colleges.

That the astonishing decision of the Judiciary Committee will not meet with approval I feel assured; and, moreover, when it is remembered that the Chairman of the Judiciary Committee is a member of one of the schools taking advantage of the quibble, we cannot but think that his offences influenced his conclusions. Yours truly,

THOMAS OPIE, M. D.

## MEDICAL PROGRESS.

CARELESS POISON-BUYERS.—Veteran druggists, says the *Bulletin of Pharmacy*, realize the necessity of questioning sharply all would-be purchasers of poisonous drugs. Where the customer has made no mistake in the name of the article needed—and such blunders are very common—he is very likely to err in the dose or the proper mode of application. The same misuse may be made

of a poisonous drug when dispensed on a prescription, if no questions be asked. This is well illustrated by the experience of a druggist in Greenville, N. J., who cites the following cases :

One day a woman asked for sugar of lead. Inquiring its purpose, the druggist learned that "the doctor had prescribed it for her baby — a teaspoonful in every bottle of the baby's milk!" She nearly fainted when told how near she had come to poisoning the "precious." A schoolboy came in to buy five cents' worth of oxalic acid — "Pawnee Bill" up the street had sent him for it; the lad wanted citric acid for lemonade. "Bill's" patrons escaped that time. At another time a woman brought in a prescription for aconite and stated that she was going to administer a teaspoonful every hour to a fever patient. The physician had instructed her to administer a teaspoonful of a dilution in a glass of water, but she had forgotten that important part of the directions and was about to enjoy a glorious debut as an angel-maker. A man with a wart as large as a pea applied for nitric acid wherewith to burn the growth. He was cautioned to put the smallest possible portion in the center of the wart. Instead he applied it generously, and in ten minutes the acid had eaten through to the bone, causing a wound that required healing by a doctor's fee.

Constant vigilance is demanded in sales of this kind, and the service thus rendered is not always thankless, for, prone as human nature is to forget its debts of gratitude, a close escape from poisoning is a wholesome and lasting object lesson on the uses of a careful dispenser.

\* \* \*

**CLINICAL USE OF DIPHTHERIA ANTITOXINE.**—Dr. W. H. Parks (*Boston Medical and Surgical Journal*) reaches the following conclusions on this subject : Diphtheria antitoxine has a distinct curative effect in diphtheria. The results are better when the injections are used early in the disease and when the diphtheria is uncomplicated with pneumonia or sepsis. The total amount required in

the treatment of a case varies from 1000 to 4000 units, Behring's standard, and is determined by the severity and duration of the disease and the weight of the patient.

An injection of 100 to 200 units of antitoxine in a person will give an almost certain immunity from diphtheria for four weeks. If security is desired for a longer period the injection must be repeated.

Diphtheria antitoxine will not cure all cases of diphtheria even if given early in the disease. It does not destroy the diphtheria bacilli. It is desirable, therefore, with the antitoxine, to use other treatment, both local and constitutional.

The injection of diphtheria antitoxine with its accompanying horse serum is accompanied in a moderate percentage of the cases with disagreeable results, but in very few with any serious ones. No cases have been observed in which the kidneys showed any evidence of being seriously affected. It does not appear to have any deleterious effects on the blood other than to cause a moderate temporary diminution in the number of red blood-cells, and even this is more than counterbalanced by its lessening the action of the diphtheria poison.

\* \* \*

**THE TIME THAT FOOD SHOULD BE TAKEN.**—It is evidently the intention of nature, says the *Charlotte Medical Journal*, that we should put into the stomach a certain portion of food, the excitement of which, inducing a secretion of gastric fluid by its action, becomes digested. This office of the stomach being effected, it should be left in a state of repose till its powers are restored and accumulated, and this return of energy would in health be denoted by a return of appetite. It is probable that three hours may elapse in health before digestion of a moderate meal is effected, so that the stomach is empty and in a state of repose. It is therefore reasonable to allot the same portion of time for the same purpose when the organ is disordered, whilst we have diminished the quantity of our food in order to proportion it to the diminished powers of

the organ ; yet instead of pursuing this rational plan of diet, many persons are taking food every third or fourth hour, pleading in excuse for such conduct that they cannot do without it. The truth is, that when the stomach is disordered the exertion of digesting a single meal after its excitement and efforts have ceased, is productive of languor, sinking and inquietude, which ought to be calmed or counteracted by medicines and not by food, for a second meal cannot be digested in this state of the stomach. We also often tease and disorder our stomachs by fasting for too long a period ; and when we have thus brought on what may be called a discontented state of the organ, unsuiting it for its office, we sit down to a meal, and fill it to its utmost, regardless of its powers or its feelings. The rules, then, for diet may be thus summarily expressed : we should proportion the quantity of food to the powers of the stomach, adapt its quality to the feelings of the organ, and take it at regular intervals of six or seven hours thrice during the day.

\* \* \*

PENETRATING WOUND OF THE EYEBALL.—Whether to remove an injured eyeball or not is a question demanding judgment and consideration. Dr. Casey A. Wood, in discussing this subject in the *Medical News*, divides ocular traumatism into three classes.

1. Those that are serious or not, from the standpoint of sight only, in which we are mostly concerned in asking whether or not the patient is likely to have useful vision in the injured organ.

2. Those that threaten the integrity of the second eye, quite apart from the fate of the injured eye, whose vision may at the time be fairly useful; here the eventual vision of the injured eye must be subordinated to the protection of the fellow organ.

3. Those cases, probably the most numerous, in which sight is destroyed in the injured eye, and anxiety may be felt in respect to the vision of the other eye. In conclusion he says : The eye is never to be enucleated or eviscerated in injuries of the first class ; it is to be

closely watched in all examples of the second class, and to be removed unless both eyes become and remain quiet. Lastly, injured eyes of the third class should always be removed.

As an aid to prognosis and treatment, I would suggest the following rules :

1. As long as the wound heals without difficulty and no sympathetic irritation exists, I would treat with rest and antiseptics and would not remove any eye whose injury is confined to the cornea, iris and lens.

2. I would not enucleate an eye containing a foreign body when the injury was confined to these tissues and the foreign body could be removed.

3. I would not remove an eye containing a foreign body if there were no injury in the ciliary region and the missile had passed through the posterior wall of the globe.

4. I would not immediately excise an eye injured by small shot (which are usually aseptic missiles), even if the wound were in the ciliary region, provided the patient could be occasionally seen by an oculist.

5. I would always excise an eye that contains a foreign body that could not be removed.

6. I would excise an eye in which the ciliary body had been injured, even if the sight were not much affected thereby. The only exceptions I would make to this rule are small gunshot-wounds, cases in which the second eye is useless or had been removed, and those instances in which there is no continued uveitis of the injured eye, provided always that the patient could be frequently seen by an oculist. For the average man, however, excision or exenteration would be, by far, the safest procedure in the last instance. When loss of sight goes along with ciliary involvement there can be no argument in favor of retaining the eye.

7. When once ophthalmia migratoria has set in, it is wise to retain the injured eye, if there be any sight in it, as eventually it may be the better of the two.

8. It is safe and proper to remove all continually tender or inflamed eyes of adults whose vision has been lost from a

penetrating wound in whatever region of the globe.

9. It is highly desirable to retain the eyeball in patients under twenty years of age, if it can be done with safety to the better eye, as earlier removal of the globe retards the growth and development of the corresponding orbit, and greatly alters and mars the facial expression.

\* \* \*

THE PHENYL-HYDRAZIN TEST FOR SUGAR IN URINE.—Dr. R. T. Williamson of Manchester, says the *Lancet*, has recently published in brochure form the results of his experience of the value of the phenyl-hydrazin test for sugar in urine for clinical work. He points out that the test may yield crystals from normal urine if the mixture is heated too long, but he has never succeeded in obtaining these crystals when the urine was boiled in a test-tube for two minutes only, a fact which he thinks removes the objection that the test is too sensitive. He proceeds as follows: A test-tube of ordinary size is filled for about half an inch with powdered hydrochlorate of phenyl-hydrazin; then acetate of soda in powder is added for another half-inch. The test-tube is next half filled with urine and boiled over a spirit lamp. By shaking the tube the salts soon dissolve; after the liquid has reached the boiling point, boiling is continued about two minutes. The tube is then allowed to stand and is finally examined. If sugar is present a yellowish deposit forms at the bottom of the tube, and on microscopical examination this deposit is seen to consist chiefly of beautiful needle-shaped crystals of a bright sulphur-yellow color. The test can be performed and the characteristic crystals easily obtained even if the urine contains a large quantity of albumen, the crystals of phenyl-glucosazone being easily distinguished under the microscope from the amorphous granules of coagulated albumen. By the manner of proceeding just described no crystals are obtained, it is said, in normal urine. Small crystals, which may be due to glycuronic acid or to minute traces of sugar, are, however, obtained on pro-

longed heating; but phenyl-hydrazin possesses the one distinct advantage over Fehling's test that it gives no reaction with uric acid, creatinine, or hippuric acid. Some of the disadvantages of the Fehling test to which Dr. Williamson alludes are avoided, we may point out, by the use of ammonia with Fehling's solution, as suggested by Dr. Pavy.

\* \* \*

THE HEART.—In the year 1650, says Professor Roswell Park, there was a celebrated dispute about the position of the heart. It appears that the Margrave of Baden had been very sick, and his house physician wanted to apply a blister, and he wished to place it directly over the center of the thorax. Some of the consultants claimed that the heart was not situated in the center of the thorax, but on the side. To settle the dispute a hog was brought in and opened and the heart was found on the left side. Then the margrave dismissed his house physician for his ignorance in thinking that a margrave's heart was differently located from any other hog's.

\* \* \*

RAILWAY DISCOMFORTS.—We have plenty of societies of railway surgeons, says the *Medical Record*, and we have a copious supply of insurance companies of all kinds. We have also very many enterprising railway companies, but there is no organization which takes upon itself the task of supervising or suggesting measures for the sanitary improvement of railway travel. We, in America, boast often of the superiority of our cars, and of our tracks, and of the swiftness of our express trains, but those who travel much cannot fail to see there are numberless deficiencies, which a little more intelligence and care on the part of railways might correct. The ventilation, for example, of our so-called parlor-cars is admitted to be an utter failure. The cars are close and stifling in winter, and hot beyond endurance in summer. There seems to have been no real intelligence or special skill in ventilation applied to the architecture of the American parlor-car. The question of smoke, and dust, and cinders, is one

also which deserves attention, from a sanitary point of view. The harm done to the eyes and to the mucous membrane of the nose and respiratory tract, by the constant inhalation of more or less carbonaceous particles, is certainly very considerable, and one that must eventually amount to something to the commuter. The question of the water-supply upon cars and of the food furnished upon them and at railroad stations is also one that well deserves the supervision of the sanitarian. In fact, if a national congress on railway hygiene were organized in this country, we feel sure that it would be able to secure a great many interesting papers, and would, perhaps, stir up a sentiment in favor of better and more sanitary conditions of railway travel, the result of which would be to keep a great many of the Americans, who now go to Europe, at home.

\* \* \*

**PEPPER ON TYPHO-MALARIAL FEVER.**—Drake anticipates Woodward in the attempt to establish the existence of a *tertium quid* formed by the blending of typhoid and malarial infection. It seems to be an easy thing to fall into this mistake when one is dealing with typhoid and malarial fevers simultaneously on a large scale. The occurrence of a malarial complication of typhoid and of a typhoid state in malarial fevers is familiar; and it may be possible that the co-existence of the two microbes may so modify the blood and tissues as to influence the toxine and antitoxine developed and the consequent phenomena of the disease, but the accounts furnished by Drake, just as the later and more elaborate descriptions by Woodward, fail to convince that such modifications go far enough to constitute a specific difference which would justify the creation of another species of fever.

\* \* \*

**THE DISAPPEARANCE OF THE FIRST SOUND OF THE HEART IN TYPHOID FEVER.**—Dr. Charles Mongour (*Archives Clinique de Bordeaux*) having noted many cases in which, during an attack of typhoid fever, the first sound of the heart disappeared, has drawn from a

study of these cases the following conclusions :

1. The disappearance of the first sound of the heart in typhoid fever points to a myocarditis.

2. If this disappearance coincides with an acceleration of the cardiac rhythm, there is likely besides the myocarditis, the action of microbic poisons on the nervous accelerating or retarding centers or on the peripheral vessels. This microbic poisoning is usually more serious than the myocarditis, which generally disappears.

\* \* \*

**NITRATE OF SILVER IN TYPHOID FEVER.**—I am convinced, says Professor Pepper, that it is a grievous mistake to omit the use in conjunction with hydrotherapy, of some suitable remedy adapted to the state of the affected mucous membrane and to the septic condition of the intestinal canal. I doubt not that others have learned to use various remedies for this purpose with good results ; as for myself, I must state that for so many years I have used nitrate of silver in every case of typhoid fever under my care, and with such apparent benefit, that I greatly prefer it to all other intestinal antiseptics ; and indeed, as you well know, it possesses extremely high antiseptic power in addition to its remarkable local action on the mucous membrane.

\* \* \*

**EXTIRPATION OF A LARGE CEREBRAL TUMOR.**—At the late German Surgical Congress (*Boston Medical and Surgical Journal*) von Bramann of Halle exhibited a patient from whom a voluminous sarcomatous tumor of the cerebrum had been extirpated. This tumor had caused a paralysis of the left arm. It was as large as the closed fist ; occupied the motor region of the right hemisphere, and had invaded the dura mater and inner wall of the cranium. The gap in the bone resulting from the operation measured twelve centimeters. The patient made a good recovery, and though three years have elapsed, there has been no return of the sarcoma. The paralysis has completely disappeared, and the patient is able to work.

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BALTIMORE, NOVEMBER 2, 1895.

ONCE more the time is near at hand when the Medical and Chirurgical Faculty of Maryland will hold its semi-annual meeting and it is with pleasure that attention is called to the meeting this year. Many years ago the Faculty held a few semi-annual meetings, but from lack of interest or from other reasons they were not a success, and after a few years were abandoned. Not many years ago it was thought the time was ripe for reviving the meetings and through the energies of Dr. T. A. Ashby and others on this committee they have been held each year and they have not only been a source of pleasure and profit to the visiting and local profession, but have served to knit closer together the profession in all parts of the State of Maryland.

The custom of holding these meetings first on the eastern and then on the western shore of the State has been adhered to as far as pos-

sible, but this has not prevented them from being held in the most feasible and desirable places. This year it has been decided to go to Belair, the principal town of Harford County, and it is pleasant to record that the local profession in Belair, and even the whole Harford County Medical Society, which is an active and hard working body, has taken the greatest interest in this meeting and will welcome the profession of the State to its hospitable county.

Complete arrangements have not yet been made, but the committee desires to procure for the programme short, interesting and instructive papers and all members of the profession are requested to make known to Dr. Hiram Woods, 816 Park Avenue, as soon as possible the titles of their papers. Only a limited number of papers will be read in order to leave time for discussion. Belair is reached from Baltimore in a little over an hour by the Baltimore and Lehigh Railroad, a narrow gauge road running from Baltimore. The station is a short distance from Union Station and a car line runs directly from Camden Station to this road, and all physicians both in and outside of Baltimore can reach the Belair station very conveniently. It is probable that railroad and hotel arrangements will be made and in a future issue the full details, cost of tickets, hotel rates and the time of trains will be published for the convenience of members.

Physicians are cordially invited to be present at this semi-annual meeting whether they are members of the Faculty or not and whether they intend to take part in the deliberations or not.

\* \* \*

THAT iron is one of the best and most universally used tonics is well known and that there is a constant search after Iron, a preparation of that metal that is both palatable and effective is well shown by the large number of preparations that are yearly put on the market.

The profession has so often been disappointed that when a new iron compound is announced the presumption is either that it is very unpalatable or that it contains very little of the most important ingredient. Probably the most generally employed form in which iron is taken by the public is in the tincture of the chloride, which is not only exceedingly unpleasant to the taste,

but is injurious to the teeth from the presence of the muriatic acid, which acts on the teeth and deposits the iron in solution. This too in spite of these many drawbacks is generally conceded to be the best form in which iron can be given.

Other salts of iron have their advantages; fancy and proprietary articles containing iron, and not bad to the taste, are put on the market and meet with approbation, but few come up to the old reliable tincture in anemia and lack of tone. With each season an enterprising drug house presents to the profession small bottles containing a highly lauded form of iron. This has a run and for a time is used extensively but sooner or later the nasty old tincture of iron is taken up again and its superiority over all other competitors is so evident that once more it reigns until some pretender, for a while at least, again holds sway. This shows that the practitioner is looking for a form of iron which shall possess all the virtues, and this is still a problem for the chemist to solve.

\* \* \*

It is hardly a credit to preventive medicine that typhoid fever has become prevalent in so many localities. If there is **Typhoid Fever**, one disease which, according to all theories of preventive medicine, should not exist, it is typhoid fever and yet it is a disease which rarely fails to "bob up serenely" each fall month and strike terror in many families.

In not a few cases it is so easy to trace this disease to drinking water or milk and such a difficult matter to stop the use of these fluids. Shutting the gates of a city after the enemy is within may entertain the enemy but it does little good to the attacked, unless the latter can so cut down and disable the enemy that no further injury will result.

In a country district it is rather easy to trace the origin of typhoid fever, but in a crowded city it is very difficult, particularly in the case of such an insidious disease, to find out what was the contaminating cause. In looking over the health statistics of Baltimore, for example, the few cases of typhoid fever reported are very noticeable. In the present week, for example, eighteen cases are reported, with nine deaths. This shows very clearly that physicians do not report their cases in the city and hence do not help the

health office to trace the disease to infected water or milk. It is very easy to grow careless in this duty.

This difficulty would in part be removed if the physician could simply be made to communicate the diagnosis to the responsible householder and then the latter, under penalty of a fine, would report the condition of things to the health office. This would insure a more careful and exact record of such cases and in the best way the further spread of the disease would be stopped.

\* \* \*

WHEN a lay paper attempts to take up seriously a reform in a department about which it knows little or nothing, **Vivisection**. it usually accomplishes no results and inspires no confidence. *Life*, which was at one time such a bright and clever weekly, has of late seen fit to take up the subject of vivisection and after publishing some twaddle by old ladies of both sexes, it attempted to take up the cudgels with Dr. George M. Gould of the *Medical News*. Dr. Gould went so far as to give a very sensible and convincing reply to what *Life* had said, but he evidently went beyond that weekly's depth, judging from the inane comments made by the editor of *Life* on this letter.

This whole controversy, which is an attempt to bring discredit on certain teachings in medicine and experimental physiology, shows how readily and easily a paper, just as a person, will talk about what it knows least about. No one, lay or medical, believes in torturing animals of any kind and no physician vivisects animals to see them suffer. Most vivisection is done on animals made insensitive to pain. As well might it be said that surgeons vivisect patients when they operate on them.

Dr. William Osler of the Johns Hopkins University has written to the *Medical News* that he has neither bought nor looked at a copy of *Life* since it published those venomous articles and cartoons on vivisection. If a weekly comic paper endeavors to dip into a subject on which it is lamentably ignorant it must expect reproof from its betters. Some critics have said that *Life* is deteriorating. If this be true it need not hasten matters by setting a large part of the intellectual community against it.

MEDICAL ITEMS.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending October 26, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		21
Phthisis Pulmonalis.....		19
Measles.....	27	
Whooping Cough.....	5	1
Pseudo-membranous Croup and Diphtheria. }	11	3
Mumps.....	1	
Scarlet fever.....	7	
Varioloid.....		
Varicella.....		
Typhoid fever.....	18	9

Typhoid fever is prevalent in Toronto, Canada.

The *New York Medical Abstract* has been discontinued.

Sherwood, Maryland, is having a small outbreak of diphtheria.

Dr. Frank Parsons Norbury is editor of the *Medical Fortnightly*.

The *Medical and Surgical Reporter* has moved back its publishing office to Philadelphia.

The metric system of weights and measures will be adopted in the next issue of the British Pharmacopeia.

The *National Popular Review* of California has been consolidated with the *North American Practitioner* of Chicago.

Dr. James Thorburn of Toronto has been elected president of the Canadian Medical Association for the ensuing year.

Dr. A. D. McConachie has removed his offices from 307 North Charles Street to 16 West Franklin Street, where he will also reside.

Messrs. E. B. Treat & Co. of New York will publish the *Archives of Pediatrics* in an enlarged form, beginning with January 1, 1896.

The *St. Louis Medical Journal* divides physicians into three classes: Those who read, those who do not read, and those who pretend to read.

Dr. A. J. Seymour, a prominent physician of Buffalo, was accidentally killed by a train

in that city. Dr. Seymour was forty-two years of age.

The Fifth Annual Meeting of the American Electro-Therapeutic Association was held in Toronto, Canada, September 3, 4 and 5, 1895. The next meeting will be held in Boston in September, 1896.

The death of Sir Thomas Longmore, C. B., honorary physician to Queen Victoria and for many years Professor of Military Surgery in the Army Medical School, is announced in the London journals.

A doctor's stable club has been organized in New York by which physicians will be enabled to keep their horses and enjoy the services of a carriage maker, harness maker and blacksmith all for thirty dollars a month apiece.

The Medical and Chirurgical Faculty of Maryland will hold its Semi-Annual Meeting this year at Belair, Harford County, Tuesday and Wednesday, November 19 and 20, 1895. Please send titles of papers to Dr. Hiram Woods, 816 Park Avenue, not later than November 5.

Dr. Charles L. Greene of St. Paul publishes in his local journal an interesting article entitled "A Suggestion Bearing upon the Treatment of Persistent Vomiting by a New Method," a careful perusal of which fails to show any new method of vomiting other than that practiced so effectually at sea.

At the last meeting of the Obstetrical and Gynecological Society of Baltimore, the following officers were elected for the ensuing year: President, Dr. William S. Gardner; First Vice-President, Dr. J. Edwin Michael; Second Vice-President, Dr. William P. Chun; Secretary, Dr. J. Mason Hundley; Treasurer, Dr. James M. Craighill.

The American Public Health Association meeting at Denver, October 1 to 4, elected the following officers for the ensuing year: Dr. Eduardo Liceaga of the City of Mexico, President; Dr. A. A. Woodhull, U. S. A., First Vice-President; Dr. Henry Sewall of Denver, Second Vice-President; Dr. Irving A. Watson of Concord, re-elected Secretary; Dr. Henry D. Holton of Brattleboro, Vermont, Treasurer; Executive Committee: Drs. J. C. Schrader of Iowa City, Iowa; R. S. Goodwin of Thomaston, Connecticut; J. F. McShane of Baltimore, Maryland. The next place of meeting will be Buffalo, New York.

## WASHINGTON NOTES.

At the regular meeting of the Medical Society of the District of Columbia, held on October 16, the President, Dr. S. C. Busey, in the chair, Dr. B. A. Storch read a paper on "Puerperal Septicemia and Antisepsis."

Dr. J. Wesley Bovée presented specimens of multiple fibroids, with hydro- and pyo-salpinx. The following Wednesday, at the regular meeting, the programme was carried out as follows: Dr. Mary Parsons, "Bandage for Displaced Kidney." Dr. T. U. McLaughlin, "Bicycling as a Cause of Prostatic Disease." Dr. E. L. Morgan, "Did Jenner Discover Vaccination?" Dr. G. N. Acker, "Abscess of Liver; Case and Specimen."

At the regular business meeting of the Washington Obstetrical and Gynecological Society, held on the 18th inst., the following officers were elected for the ensuing year: President, Dr. George Byrd Harrison; Vice-Presidents, Drs. S. S. Adams and G. N. Acker; Recording Secretary, Dr. G. Wythe Cook; Corresponding Secretary, Dr. W. Sinclair Bowen; Treasurer, Dr. John Van Rensselaer. The following committees were also elected: Business Committee, Drs. John T. Winter, E. L. Tompkins and W. S. Bowen; Publication Committee, Drs. G. Wythe Cook, Wm. Mercer Sprigg and Henry B. Deale; Committee on Admissions, Drs. W. M. Sprigg, H. B. Deale and M. F. Cuthbert. After the election the members repaired to the dining room, where an elegant banquet was served at the Arlington Hotel.

Dr. James Kerr, Surgeon to the Providence and Emergency Hospitals, has resigned the Professorship of Surgery in the Georgetown University and was soon after elected Clinical Professor of Surgery in the Columbian University.

Dr. William Holland Wilmer has been appointed Oculist to the Garfield Hospital.

Dr. Walter Reed of the Army Medical Museum has been appointed Professor of Bacteriology in the Columbian University.

The regular meeting of the Clinico-Pathological Society was held on October 15. The following officers were elected: President, Dr. H. B. Deale; First Vice-Presidents, Dr. A. A. Snyder and Dr. W. J. Dillenback; Recording Secretary, Dr. R. T. Holden; Treasurer, Dr. Taliaferro Clark; Corresponding Secretary, Dr. R. M. Ellyson. The following

committees were also elected: Business Committee, Drs. J. K. Wellington, T. R. Stone and Louis M. Mackall. Publication Committee, Drs. R. W. Baker, Frank Leech and J. Van Rensselaer. Committee on Microscopy, Drs. L. W. Glazebrook, Sterling Rufin and Thomas J. Kelley. The meeting then adjourned.

## PUBLIC SERVICE.

OFFICIAL LIST OF CHANGES IN THE STATIONS  
AND DUTIES OF MEDICAL OFFICERS.

## UNITED STATES ARMY.

*Week ending October 28, 1895.*

Leave of absence for one month, with permission to apply for an extension of two months, is granted First Lieutenant James M. Kennedy, Assistant Surgeon, Camp Merrit, Montana.

Captain Ogden Rafferty, Assistant Surgeon, is relieved from duty at Benicia Barracks, California, and ordered to Fort Bliss, Texas, for duty, relieving Major Clarence Ewen, Surgeon.

Major Clarence Ewen, Surgeon, upon being relieved from duty at Fort Bliss, Texas, will proceed to San Francisco, California, and report to the President of the Retiring Board for examination.

The leave of absence granted Major Charles B. Byrne, Surgeon, is extended three months. Captain William H. Conbusier, Assistant Surgeon, to be Surgeon, with the rank of Major, October 17, 1895, vice Cronkhite, retired from active service.

Major Henry M. Cronkhite, Surgeon, retired October 17, 1895.

Captain William H. Arthur, Assistant Surgeon, is granted leave of absence for one month.

## UNITED STATES NAVY.

*For Two Weeks ending October 26, 1895.*

Medical Directors G. S. Beardsley and P. S. Wales ordered to duty as members of the Naval Examining and Retiring Board.

Passed Assistant Surgeon J. S. Sayre ordered to treatment at the Philadelphia Naval Hospital.

Passed Assistant Surgeon C. H. T. Lowndes detached from the naval hospital at Mare Island, California, and ordered to the marine rendezvous, San Francisco, and in attendance on officers in that city.

Passed Assistant Surgeon C. J. Decker detached from the marine rendezvous and special duty in San Francisco and ordered to the naval hospital at Mare Island.

J. C. Rosenbleuth appointed assistant surgeon in the Navy, October 14, and to instruction at the Naval Laboratory, October 25.

**CURRENT EDITORIAL COMMENT.****MUNICIPAL HYGIENE.***Cleveland Medical Gazette.*

If the object of municipal government is the promotion of the health, happiness and general welfare of the citizens, then nothing can be of greater importance than clean streets, pure air, good water and efficient sewerage. To secure this is expensive, but could be easily provided for if great monopolies were made to pay their just proportion of taxes, and rich men could not establish fictitious residences to evade payment of taxes.

**BICYCLING FOR WOMEN.***Canadian Medical Review.*

In the majority of instances women are rendered more healthy by the judicious use of the wheel as a means of gaining fresh air and exercise. There is much to be desired in the way of a suitable saddle. With the saddle at present in use, if the handle bars are low, pressure of the front part of the saddle may come where it will produce irritation, local excitement or pain in the parts pressed upon. This may be avoided by riding in the erect posture with the handles high, but a broader seat without the front projection as found in the saddle of today would overcome a great deal of the difficulty.

**DIPHTHERIA.***Archives of Pediatrics.*

THE recent tendency to speak of "bacteriological diphtheria" is unfortunate. Diphtheria is a disease, not a microbe. A person may have the microbes, but if he does not have the disease he does not have diphtheria. The accident of having the bacilli of diphtheria on the coat sleeve does not mean that the wearer of the sleeve has diphtheria. Nor does the accident of having them on the mucous membrane of the throat necessarily mean diphtheria, though it is, to be sure, more probable. Both persons may be dangerous to others, but that again does not constitute diphtheria. It does not seem possible that a person can remain long in a room with a serious case of diphtheria without the lodgement of a certain number of bacilli upon the mucous membranes, yet how infrequently do adults contract the disease. The presence of bacteria does not necessarily mean the occurrence of disease.

**PUBLISHERS' DEPARTMENT.**

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

The safest mode of remittance is by bank check or postal money order, drawn to the order of the *Maryland Medical Journal*; or by registered letter. The receipt of all money is immediately acknowledged.

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**NOTES.**

THE chlorate of potassium should never be employed internally in cases of diphtheria.

\*

BISMUTH, silver nitrate and lead acetate are not only astringents, but also sedatives; all other astringents are irritants.

\*

ONE quarter of a drop of carbolic acid every hour, for a few hours, will often stop vomiting coming on after etherization.

\*

IF a person's temperature should be found to persist above 100° without any apparent cause, tuberculosis should be suspected and sought for.

\*

IF a minim of carbolic acid be added to a hypodermic syringeful of a drug, it will cause the absorption of the drug to go on more slowly.

\*

ANEURISMS of the aorta, arising before any branches have been given off, excluding those due to infectious diseases, are almost always due to syphilis.

\*

ALL cases of convulsions which are due to a diseased condition of the spinal column will be greatly benefited by the employment of amyl nitrite.

\*

IN cases of lacerated and contused wounds, there exists a great danger of intermediate or reactionary hemorrhage, at the time at which the patient recovers from the shock.

\*

IF during a case of labor the patient complains of much pain in the region of the back, pressure made in this region during the time of a pain will generally afford great relief.

# MARYLAND

# MEDICAL JOURNAL

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## ORIGINAL ARTICLES.

### THE TREATMENT OF DIPHTHERIA WITH DIPHTHERIA ANTITOXINE.

READ BEFORE THE PHILADELPHIA COUNTY MEDICAL SOCIETY, SEPTEMBER 11, 1895.

By Edwin Rosenthal, M. D.,

Philadelphia.

To ROBERT KOCH and his associates is the honor due for laying the foundation that led to the discoveries of the various pathogenic micro-organisms—tuberculosis, typhus, diphtheria, cholera, etc. In his work (*Untersuchungsmethoden von pathogenen Organismen*), Koch gave an impetus to the study of bacteriology, which at the present time is the common property of the scientific world. The etiology of diseases was investigated; the results of these investigations demonstrated and proven. The diagnosis of diseases was by the means of bacteriology rendered easy and certain, and now the realms of the therapeutists have been invaded and the bacteriologists give to the clinician new remedies and new methods. This transition is the natural sequence of the present doctrines concerning the infectious diseases.

When the causes of diseases were proven, then came the study of a preventive, and thus was laid the groundwork for a rational prophylaxis. The discovery of tuberculin by Koch may be called the foundation-stone upon which all the later discoveries have been laid and which has led to that newest method—the serum-therapy of Behring and others.

Loeffler (a student of Koch) was the first to isolate and cultivate the micro-organism of diphtheria which had been previously discovered by Klebs and bears the name of Klebs-Loeffler. Discovered in 1884; small, slightly curved rods about as long as the tubercle bacilli and twice as broad, possessing no movement; do not liquefy gelatin; are not very resistant, being destroyed by a temperature of 50°C., but they have lived in blood-serum five months; grow readily on all media between temperatures of 20° and 40°C. They are facultative anaerobic, and grow quite rapidly and profusely and may be cultivated on gelatin plates, glycerine agar (stab-culture), potato (on alkaline surface—a grayish layer in forty-eight hours), and in blood-serum (after Loeffler). "Blood-serum 3, bouillon 1; the bouillon contains peptone 1 per cent., chloride of sodium  $\frac{1}{2}$  per cent., and dextrose 1 per cent." Is not colored by Gram's method; stained best with Loeffler's alkaline methylene blue (M. U. Ball.—*Bacteriology*).

Loeffler, as well as Roux and Yersin and Sydney Martin, have further investigated the disease. Their experiments have proven that it is not the mere presence of the bacilli that gives rise to all

the symptoms we meet with, but their products; that is, the ptomaines or poisonous substances produced by it.

Roux and Yersin substantiated their theory by separating the bacillus from the ptomaines, and subjecting it to chemical analysis and physiological test. They described the disease as a toxemia differing from others in the respect that the toxic acts as a ferment, which when injected into living tissues even in the most minute quantities ushered into existence certain well-defined albuminous substances or bodies. These albuminoïds were isolated by Sydney Martin from various organs obtained from persons who died from diphtheria. The substance when secured was subjected to alcohol and resolved itself into a proto- and dextro-albumose, which he injected into rabbits. In doses of 0.117 per kilo it produced a febrile condition and edema in the animal; slightly increasing the amount to 1.112 per kilo rapid death of the animal followed. Intravenous injections produced fever, progressive paralysis, and degeneration of the heart, nerves and muscles precisely analogous to those conditions resulting from diphtheria.

Brieger and Fränkel, as well as Proskauer and Wasserman, busied themselves with the further chemistry of the disease. Brieger and Fränkel, through frequent precipitation of the culture-bouillon with acetic acid and alcohol, obtained a white amorphous body which gave all the reactions of an albumen. It is soluble in water, and decomposes by high temperature.

These "toxines," as well as "antitoxines" or substances that establish immunity to specific diseases in animals, have been shown by Buchner to be probably the direct products of bacterial cells. These results, on the investigation of the products, give rise to further experiments, and Roux in France, Brieger, Fränkel and Behring in Germany, pursued the same studies leading to immunization.

Brieger and Fränkel, by injecting 10 to 20 c.cm. of a three-weeks' old culture of diphtheria bacilli, which had been heated to 70°C. for one hour, produced

an immunity in guinea pigs against the virulent form.

Behring found several ways to make animals immune. One method was to inject them with diphtheria and then inject trichloriodine in them, which prevented them from dying, and they were then immune.

The immunity of individuals against disease is understood to depend upon the destruction, by certain agents, of the supposed living cause of the disease. These agents may also act by hindering the growth of the living cause or by destroying its infectious properties by the destruction of the poisonous material produced in the infected organism, or by imparting a higher resisting power against this poisonous material.

Behring's serum-therapy is based upon these ideas and depends upon his own discovered fact: that we can through subcutaneous injections of the blood of animals which are rendered immune from certain bacteria render other animals immune against inoculation of the same bacteria; and not only does such an injection (*impfung*) protect the animal against living bacteria, but against their "toxines," as has been pointed out by Behring and Kitasato for tetanus bacilli and tetanus toxines.

This discovery of Behring's is the beginning of a new epoch in the science of immunization. Until this period immunization could only be obtained by giving the animal attenuated bacteria cultures, or solutions of cultures freed from living organism. Pasteur's methods of immunization against hydrophobia and anthrax depends upon the results of these experiments, immunization being obtained by having the individual go through a weaker or modified form of the disease, similar also to vaccination against variola with cowpock (vaccine virus). The result of passing through a milder form of disease is to protect the individual against an infection of a more virulent matter, as vaccinia modifies variola, with the result, if there be infection, varioloid.

Behring's method is entirely different; where formerly a disease was produced to protect from a more virulent disease,

now is injected into the organism a substance, harmless in itself, which protects the individual not only against infection, but if already infected from its results. To this he has given the name "antitoxine," for his assertion that another name, "gegengift"—against poison—might lead one to the belief that the antitoxine was in its name and nature a poison, a point which he emphatically desires to be known (*Das neue Diphtheriemittel*, Behring, 1894, page 10).

It is, therefore, an entirely different process of immunization from Pasteur's.

In Pasteur's method every individual receives a special virus for a special case to render immunization. In Behring's method the one virus (serum), if it has immunization powers, is capable of transmitting immunization to a whole series of cases. This has been proven in diphtheria and tetanus.

Ehrlich proposes the names active and passive immunization, to distinguish those that have been immunized with serum and those with the cultures of the disease. In the latter, the passive immunization is not lasting, because the individual has had no work put upon the cells to become immune, but has received the ready-made serum; as long as it is in the blood so long is there immunization. In the active form the individual has obtained immunization by labor obtained through the activity of its own cells. He holds this property longer. To substantiate this theory he gives as examples those individuals who have passed through an infectious disease, become immune, and retain immunization throughout life. I give as examples of his theory—vaccinia against variola—where varioloid may result for the passive; scarlatina against a reinfection for the active immunization.

The antitoxine, or "gegengift," which to the blood of immunized individuals gives that specific protection, acts specifically, so that tetanus antitoxine protects only against tetanus or diphtheria antitoxine against diphtheria.

Diphtheria antitoxine serum is obtained from the blood of animals ren-

dered immune to the disease by the prolonged injection of minute, but gradually increasing quantities of diphtheria "toxine," a fluid obtained by the cultivation of the diphtheritic bacilli in nutrient broth (*Blutserumtherapie und Geschichte der Diphtherie*, Behring).

The principles of Behring's method is followed by Roux and Aronson, as well as those that are making it in this country.

Of the precise method of obtaining the diphtheria serum; "The method first employed by Behring for the immunization of animals and consequent production of 'antitoxine' in their blood was one by which the animals were immunized to the activities of the bacillus and able to resist its growth in the body. For this purpose, dogs, goats and smaller animals were injected first with cultures of diphtheria, containing only the dead bodies of bacilli killed by heat. When these could be tolerated without any considerable local irritation, living cultures attenuated by heat were introduced to pave the way for virulent organisms, which were withheld until the vital resistance acquired was sufficient to prevent them from causing death. In this way Behring was able to produce immunity in animals ordinarily susceptible to the disease, and to discover in their blood a substance which, when secured in solution in clear serum, and introduced into animals suffering from the disease, seemed potent to neutralize the diphtheria poison and enable the animals to recover. Behring, however, foresaw that the chief source of danger in the infection was the toxic product of the bacillus, not the bacillus itself, and that a stronger serum, *i. e.*, one possessed of more of the antitoxic substance—was required to save the lives of animals into which the toxine was injected, than to save those inoculated with living bacilli.

"In the incubator in his laboratory Behring had a flask of bouillon which, having been inoculated with diphtheria bacilli, had been allowed to remain undisturbed for two years. From it every living bacillus had disappeared, the nutrient having been exhausted. Repeated

experiments showed the culture absolutely sterile, yet so great were its toxic powers that 0.1 c.cm. injected into a 500 grammé guinea pig would cause death in twenty-four hours.

"This prodigiously powerful poison was that used in the antitoxine experiments, and all Behring's energies were devoted to the production of a neutralizing substance so strong that a small quantity of it would suffice to neutralize a large quantity of the poison. So successful was Behring in his experimentation as to be able to produce an almost incredible amount of protection for guinea pigs, both against inoculation with living bacilli and injection of the poison."

For the manufacture of the antitoxine, Dr. McFarland pursues Roux's method. This depends upon the continuous and progressive introduction of a very powerful toxine into a non-susceptible animal, and the production, in this animal, of the antitoxine, by the stimulated cells of the tissues and blood. This method is pursued by him as follows: From numerous cultures of the *bacillus diphtheriae*, a particular virulent one is chosen. To be very virulent  $\frac{1}{2}$  c.cm. of a twenty-four-hour-old bouillon culture should kill a 500 grammé guinea pig in from twenty-four to thirty-six hours. With this bacillus a large flask of alkaline, 2 per cent. peptone bouillon is inoculated and placed in the incubator. At the end of twenty-four to forty-eight hours about 40 c.cm. of this culture are added to each of a number of very wide, flat flasks, with long necks and a tubulature at the side (Fernbach flasks), each containing about one liter of similar bouillon.

These flasks, after being inoculated, are also placed in the incubator for twenty-four hours, until the growth be well established, after which the cotton plugs, which have closed the mouth, and tubulature are pushed well down the tubes, rubber corks containing a glass tube inserted above the cotton, and the tubes connected with an aspirating apparatus, by which a current of air is kept passing through the flasks from mouth to tubulature.

The object of this seems to be two-fold. Fernbach, the inventor of the method, observed that the liberation of metabolic products of micro-organisms keeps pace with their vegetation, and is at its maximum when the bacilli are multiplying and dying with great rapidity, the death of each organism seeming to liberate the poison which its protoplasm contained. The primary object of the Fernbach flask was to supply the appropriate conditions for rapid vegetation by a current of fresh air. It can be readily observed that from massive cultures of diphtheria, in liquid media, especially, a pungent odor arises. The second function of the current of air is to remove this effluvium. In order not to dry up the culture medium, the air passing through the flasks is first made to pass through a wash bottle, contaminating micro-organisms being excluded by the cotton plugs in the neck of the flasks and in the tubulature. The flasks thus arranged are kept in an incubator at a temperature of  $32^{\circ}$  C. for three to four weeks, after which the toxine supposed to be virulent is filtered and tested. The filtration of the toxines is a matter requiring considerable care, as regards the filtrate, which, although devoid of bacilli when passed through the filter, is as good a culture medium for bacteria other than the diphtheria bacillus as ever. The filter used is the Chamberland. The strength of the toxine is estimated by injecting into guinea pigs, the desired strength being sufficient for 0.1 c.cm. to kill a 500 grammé animal in twenty-four hours.

If the filtered toxine be of the desired strength it can at once be used. If, however, as is the case in a great number of instances, the toxine proved weak, it should be rejected.

The animal employed by Dr. McFarland is the horse. Before beginning the treatment, it must be tested for tuberculosis and glanders with tuberculin and mallein. Much individual variation occurs among horses in their susceptibility to the action of the toxines, hence it is always well to begin the administration with a very small amount. Roux begins with 0.5 c.cm., and repeats the in-

jection about every eight days, according to the condition of the animal, doubling the amount as often as possible, and as rapidly as possible ascending to the enormous amount of 200 to 250 c.cm.

The condition of the horse during all this time must be carefully watched and estimated. The injection generally causes fever, which cannot be borne too long without danger. The appetite must be carefully noted. The animals should be weighed at rather frequent intervals. All these precautions are necessary to keep the horses from falling into a condition of cachexia, from which they recover with difficulty, if at all, and in which they can yield no antitoxine, because the blood is saturated with toxine, not antitoxine.

When the treatment has been kept up for three or four months, and the animals have reached the point at which they can stand the injection of 200-250 c.cm. without other general or local symptoms than a large edema at the point of injection, they are about ready to furnish antitoxine of value.

A trocar, with a canula attached to a rubber-tube, is passed into the jugular vein of the animal, and the blood allowed to flow through the tube into sterile glass jars prepared to receive it.

The jars are stood upon ice, after the blood coagulates, for two days or more, until the serum separates. The clear serum is withdrawn by the pipette and placed in sterile receptacles.

As with the toxines, so with the antitoxines, disappointment is liable to meet the experiment at the last moment. All the horses will not furnish the same degree of antitoxicity in their serum, and the test, which must be performed upon guinea pigs, will sometimes show that the serum from the horse, most carefully treated, is entirely devoid of antitoxic power.

If properly carried out, without haste, the horse being kept in good condition, the power of the serum should be sufficient in an almost infinitesimal amount to protect a guinea pig against the ordinary fatal dose of diphtheria toxine. The exact value of the serum obtained by Roux's method, to make it equal the

accepted standard, is that one part of it shall protect against ten times as many parts of the standard toxine. Thus, if 0.1 c.cm. of the toxine will kill a 500 grammes guinea pig, 0.01 c.cm. of the antitoxic serum should cause the animal to recover. As ordinarily expressed, 1 gramme of the antitoxine will protect 50,000 grammes of guinea pig against what would ordinarily be a fatal dose.

By injecting the toxine into a vein, and carrying out the immunization for a longer period of time, a stronger antitoxic value — even twice as strong — can be produced. As, however, a severe urticaria follows the injection of this serum into human beings, its use is not so desirable as the weaker serum.

Serum thus obtained may be kept for quite a while before using. To keep it sterile some antiseptic has been added, as carbolic acid, trikresol, camphor, or the like.

The serum does not retain its power indefinitely, but gradually loses it.

#### Of the method of using antitoxine.

The antitoxic serum is used as a curative or immunizing agent by subcutaneous injection into the tissues of the body. The parts chosen by myself, and advised by those who have first used it, is in the back between the scapulae on either side of the vertebral column. Other parts of the body, as the loins, groins, or sides of the chest, have been selected. The parts are thoroughly cleansed by means of alcohol soaked upon sublimate cotton or gauze, and after injection is hermetically sealed with iodoform collodion. For the purpose of making these injections I have used first a horse hypodermic syringe, requiring, however, two injections, as its capacity was but 5 c.cm. Later, I used a Koch 10 c.cm. syringe, and at the present time I am using a hypodermic syringe made for this purpose by an instrument maker, its capacity being 13 c.cm.

The amount of antitoxine used depends upon the time of making the injection, the age, and body weight of the individual, and the gravity of the disease; also whether for the purpose of immunization or cure. In these methods

I have followed the directions of Behring as given in his announcement with every bottle of the antitoxine.

In the first two days of the disease, if the case be one of average severity, I give an injection equivalent to 600 antitoxic normals. No matter what may be the strength of the antitoxine, I fix my dose to suit this equivalent. For the purpose of better understanding this, I may add that whilst the antitoxine as manufactured by Dr. McFarland has a certain strength, *i. e.*, each gramme being equal to 100 antitoxic normals, Behring has antitoxine of three strengths, *i. e.*: 1. Each gramme representing 60 normals; 2. Each gramme representing 100 normals; 3. Each gramme representing 150 normals. Aronson's antitoxine has the same strength as Behring's No. 3, *i. e.*, each gramme representing 150 normals. Roux's antitoxine is equivalent to Behring's No. 2, each gramme representing 100 normals; and another antitoxine, to which I give the name of Dr. J. Solis-Cohen, has the same equivalent as Behring's No. 3. Of Gibier's antitoxine I know very little of its strength but the assertion that it equals Roux's. This, however, cannot be substantiated, for an extremely large quantity (25 c.cm.) is necessary as a curative injection, which if its strength were such would be unnecessary. It would be superfluous to add the directions which come with each variety of antitoxine; it is sufficient to know the strength in antitoxic normals, to know how to apply it.

To resume. If the case be seen on the third day, or if at the beginning the infection be such that leads one to believe in the necessity of prompt treatment, as in laryngeal cases or where the lymphatics be involved, I immediately inject 10 c.cm. or the equivalent 1000 antitoxic normals. I then await results. If in six to twelve or even twenty-four hours no change takes place or the symptoms are aggravated, I inject again 1000 antitoxic normals of the serum, and so on until there be an amelioration of the symptoms shown by a decline of pulse rate and temperature and an improvement in the general condition. I

have noticed another sign which is manifested from six to twelve hours even before the pulse and fever decline and which teaches me that I have used sufficient antitoxine and that is a blood-red line surrounding the diphtheritic patches in the throat, this line so distinct that it shows the demarcation between the healthy and infected mucous membrane. When this is visible my experience has taught me to expect a very favorable result in the particular case. The quantity of antitoxine administered can increase to enormous dosage; being harmless, no danger can be apprehended. To what quantity it has been used in one single case my statistics show. My own statistics show that 2000 antitoxic normals were sufficient in the most serious cases.

The question might arise, What is an antitoxic normal? An antitoxic normal or immunity unit is an amount of antitoxic serum required to save a 500 gramme guinea pig from the minimum fatal dose of diphtheritic toxine. The number of immunity units per c.cm. gives a standard strength of the serum; for instance  $\frac{1}{100}$  c.cm. will protect a 500 gramme guinea pig, therefore 1 c.cm. would protect 50,000 grammes or 100 guinea pigs against the minimum fatal dose; 1 c.cm. of antitoxic serum, which protects 50,000 grammes of guinea pig, contains 100 antitoxic normals or immunity units, and would protect an individual weighing 100 times as much as a guinea pig (about 120 pounds), if the susceptibility were the same. As the susceptibility might be the same I give an injection, as an immunizing dose, of 100 antitoxic normals (immunity units) to perfectly healthy individuals exposed to the contagion of diphtheria. That this theory is the correct one and my dosage the correct dose, since I have practiced this Behring (Meister Lucius and Brünning Höchst a M.) has placed before the profession another bottle which he terms No. 0, containing 200 antitoxic normals (immunity units) for immunizing purposes. This he terms an immunizing dose, and is sufficient for healthy children and adults. It protects them against exposure, and even if exposed

and shows evidence (Loeffler bacilli) of such exposure. To protect individuals who may be exposed by coming into the neighborhood of such infection one-half of this quantity, 100 antitoxic normals (immunity units), is sufficient. To further protect individuals who have been immunized Behring orders that the dose be repeated in eight weeks.

The question now arises, Is diphtheria antitoxic serum a cure for diphtheria? For diphtheria pure and simple where there exists no other infection, I am prepared to say yes. Where, however, other infection exists, manifested by other symptoms demonstrated by other indications, and proven by bacteriological examination, I must modify this reply, and though my success and statistics have been extraordinary, I think it only proper and truthful to say that this is due to a recognition of the other complications, and a prompt and careful specific treatment of the same. It is, therefore, a very rational explanation of the brilliant results which the early use of antitoxine have given. When used before the diphtheria toxines have so invaded the tissues as to destroy them, antitoxine is a specific. But where the complex symptoms are such (the degenerations of muscles and nerves, or the toxemia or septicemia) that life cannot exist, this or any other method of treatment cannot cure. Understanding diphtheria with all the complications that can arise (infection from streptococci, staphylococcus, pneumococcus, etc.), I modify the treatment and pursue the following method:

After injection of the serum, whether the case was one requiring intubation or not, whatever the variety may be, I immediately ordered a purgative to rid the alimentary canal of any infectious bacilli. For this purpose I give calomel, combining it with salol. I give it hourly, in suitable dosage, until characteristic evacuations, when I cease its administration. At the same time, I administer a judicious amount of stimulants and food. If any complication exists which by its presence endangers life, I administer the antitoxine, but I pay no more attention to the diphtheria except the

stimulation and treat that symptom. For example, if it be a pneumonia, my whole energies are directed to that, or if it be a nephritis, my whole treatment is directed toward the kidneys. That this is the correct method my recovery of the cases can demonstrate. In one case of pneumonia, in the practice of Dr. Metzler, our treatment was mainly directed to the lung infection, and the result was a cure. The same incident was noted in the practice of Dr. H. H. Freund. In a case of tubal nephritis (acute), seen by Dr. Van Gasken (health inspector of the district), no other remedial agents were employed but those commonly used in such affection. I can, therefore, safely assert that whilst antitoxine is a specific in diphtheria, it is not a cure-all; and if reliance be placed on this remedy alone, disappointment will be the rule instead of the exception. That diphtheria antitoxic serum has curative virtues, none who understand the clinical manifestations of the disease should deny; still there are many who by word and pen decry its virtues and give to it credit for nothing, and even go so far as to place to its credit downright harm. I have been enabled to gather as many of these monographs together as I could and to see upon what grounds this antagonism exists. To combat these assertions, I had prepared a list of questions containing also the points upon which the antagonists of antitoxine lay particular stress. These questions I have sent to as many physicians as I was able, and who I learned have used the serum, with the purpose of coming to an accurate and truthful conclusion. Besides this, I sent the same questions to the hospitals of different cities with a chart asking for statistics, etc. Whilst my colleagues in private practice have been both kind and prompt in their responses, I must regret to say that I will be unable to give the statistics of the different hospitals, for the simple reason that while the question may be of vital interest to us as private practicing physicians, a sort of red-tapism protects some of the hospitals from exposing their statistics, and where I really expected some coöperation, a lack of considera-

tion or probably other and more valuable duties prevented such a request being granted. However, I strove to make this omission good by requesting the Board of Health of three of our large cities for statistics which might answer somewhat my purpose. Mr. Turner, of our Board of Health, kindly referred to Dr. Taylor, who referred me, etc., and consequently I cannot produce Philadelphia statistics; Dr. Roger S. Tracy,

Register of Records, the New York Board of Health with New York; and Dr. S. H. Durgin, of the Health Department, Boston, Mass., with Boston. The questions I gave to each were precisely the same, and were a request of the returns received in each office of a case of diphtheria, as well as the returns of the deaths, for each month from 1886 until the present month.

### CLINICAL LECTURE.

## RECENT SALPINGO-OÖPHORECTOMY; VAGINAL HYSTERECTOMY; OVARIOTOMY.

DELIVERED AT JEFFERSON HOSPITAL, OCTOBER 15, 1895.

By E. E. Montgomery, M. D.,

Professor of Clinical Gynecology in the Jefferson Medical College; Gynecologist to Jefferson and St. Joseph's Hospitals; President Alumni Association of Jefferson Medical College, Philadelphia.

GENTLEMEN:—In my first lecture I informed you it was my purpose to show you the patients upon whom the various operations were performed, or where I could not do this, give you the results of the method of treatment. In conformity with that promise, the first patient I show you is one upon whom we operated three weeks ago, removing both ovaries and tubes on account of a hydrosalpinx of one, and a hematosalpinx of the other. I bring her before you today, and expose the wound. You see the line of incision has healed completely. She has had no unpleasant sequelae and the convalescence has been uneventful. By the temperature record you will notice that it reached 100° the second day; it has never exceeded this, and the third or fourth day it began to subside and is now running normal.

*Vaginal Hysterectomy.*—The second temperature sheet is that of a patient who underwent vaginal hysterectomy two weeks ago for malignant disease of the uterus. You remember the patient was one in whom the cervix was largely destroyed and it was with considerable difficulty we were enabled to get beyond the disease and at the same time avoid

injury to the ureter or bladder. The operation was performed by separating the vagina from the cervix, dissecting up between the bladder and the uterus anteriorly, then amputating the cervix before the peritoneum was opened posteriorly in order that the broken down material might be removed without danger of having the peritoneal surfaces soiled by it. Through the posterior opening forceps were applied upon the broad ligament in such a way as to secure the uterine arteries and the broad ligament, then cut between the forceps and the uterus. Another section of the cervix was then cut away and the fundus of the organ turned down. The upper portion of the broad ligament was secured by forceps outside the ovaries and tubes and the remaining portion of the organs removed. Having done this the cavity was irrigated and examined and a portion of the vagina cut away, down to the recto-vaginal septum, as the disease had extended upon the vagina posteriorly. This tissue was also seized with forceps so that at the completion of the operation seven forceps were protruding from the vagina. Iodoform gauze was packed between the forceps,

carrying it over their ends to protect the coils of intestines from impinging against them and becoming injured. Another portion was packed between and around the forceps, filling up the lower portion of the vagina. The portion of the forceps projecting from the vulva were covered with sterilized gauze and cotton so that no portion of the instruments was exposed. This portion of the dressing was changed as frequently as it became soiled. Forceps were permitted to remain for forty-eight hours. This is a longer period than is absolutely necessary, but having had experience in two cases of hemorrhage following the removal of the instruments where operation was done for fibroid growths, I preferred to leave them for a longer time and thus insure the control of bleeding. The gauze was permitted to remain four days, forty-eight hours after the removal of the instruments. Some two or three hours subsequent to the removal of the gauze, vaginal irrigation was employed. This interval was directed in order to permit the peritoneal surfaces to become agglutinated. For irrigation, hot sterile water was used. A very good agent is sulphurous acid solution 1-40. This is preferable to a solution of bichloride, as it does not produce the unpleasant result of the latter upon the peritoneal surfaces. During the first forty-eight hours the temperature reached 102°. This was before the removal of the instruments. Subsequently it immediately subsided and has since but once passed 101°. Her temperature now varies between normal and 100°. This slight elevation of temperature is undoubtedly due to the discharge of some material which was held in the grasp of the forceps.

*Ovariotomy.*—The third patient which I bring for your consideration today is a young women twenty-two years of age, single, a waitress, father and mother living, in good health, has two brothers and six sisters, all of whom are healthy. She has suffered from the common diseases of childhood and had frequent attacks of sore throat. With this exception she enjoyed excellent health up to the present illness. Pu-

berty occurred at twelve, menstruation was not very painful, but quite profuse, the flow lasting six days. The periods have occurred regularly. Last February she noticed a swelling in the left side of the abdomen, which was painless and continued to enlarge until her clothing no longer could be worn. During the time this growth has increased she has suffered no pain and the menses have been regular, she has gained six pounds in weight, appetite is normal, bowels regular, has had no nausea nor vomiting. Here we have the history of a patient twenty-two years of age, who has continued to menstruate regularly and has an abdominal enlargement. This began in February last and has increased in size, and has been particularly noticeable on the left side until it has reached the present dimensions, when the tumor has extended above the umbilicus. As the patient is under the influence of the anesthetic you see the abdomen looks almost symmetrical, but upon examination I find this tumor is situated more to the left of the median line, while the intestines are crowded to the opposite side. It becomes a matter of interest to determine the character of this growth and the portion of viscera which has given it origin. Is it a physiological or pathological condition? As the woman has continued to menstruate regularly the natural inference would be that pregnancy does not exist, although this should not be taken for granted, as it is well known that women continue to menstruate even after its occurrence. On palpation of the tumor, however, we find that the sensation of fluctuation is very distinct, indicating that there is fluid contained within it. Fluctuation would not be recognized in pregnancy excepting where the condition known as hydramnios exists, but an enlargement which has existed since February, associated with hydramnios, would be very much greater than in the case before us. The examination by the vagina has also disclosed the fact that in this patient the uterus is not increased in size, but lies below and to the left of the pelvic portion of this growth. The occurrence of fluctua-

tion also excludes the possibility of this growth being one of the uterus, as fibroid tumors of a cystic variety are exceedingly rare in a woman of her age. Then, too, as we have already mentioned, the uterus is not increased in size and lies in relation to, but not as a part of, this growth. Having excluded the uterus as being a factor in its origin and recognizing that the tumor is one in which the pelvic organs are involved, we are confined to the ovaries as the probable source of its origin. But you will ask, is it not possible that this may be free fluid in the peritoneal cavity rather than a cyst; in other words, a case of ascites. That should be constantly kept in mind in the examination of the case. In ascites, as the patient lies upon her back, the abdomen becomes flattened and broadened from side to side. In this patient, as you notice, the abdomen is quite prominent and as I palpate over it I am able to distinctly define that the tumor is limited to one side of the abdomen. Percussion discloses an absence of resonance over the surface of the mass, while there is marked resonance on the right side of the abdomen. This reveals that we have to deal with fluid confined within a sac and not free in the peritoneal cavity. In ascites the zone of resonance is over the summit of the enlargement, while flatness is noticed around this. We are forced, then, to decide this to be a tumor of the ovary, cystic, for the reason that fluctuation is distinct and it plainly contains fluid. That the fluid is contained in a single cyst is apparent from the fact that fluctuation can be distinguished from one side of the abdomen to the other. Now it is a matter of interest in the examination of this patient to determine the ovary which has given rise to the formation of the tumor. Ordinarily we determine the ovary by the fact that the resonance is situated on the opposite side of the abdomen to that from which the tumor has originated. From that in this patient we would infer that the tumor had originated in the left ovary, but upon examination of the pelvis I have discovered that there is a projection to the

right of the uterus, and the uterus is pushed to the left side. This leads me to believe that in this patient, notwithstanding the physical signs over the abdomen, we have a cyst which has originated in the right ovary; as this ovary has increased in size it has fallen into Douglas' pouch, from whence it has subsequently developed, and for some reason has become more marked upon the left side. We have determined the existence of the ovarian cyst and recognize that the only plan of treatment that affords a chance for recovery of the patient is by its extirpation.

This operation was first done in the backwoods of America by Dr. Ephraim McDowell in 1809. It was subsequently performed by a number of operators in this country, the chief of whom were the Atlees of Pennsylvania, and Drs. Dunlap of Ohio and Kimball of Massachusetts. I do not think I have ever listened to a story of more intense interest than that related by Dunlap of his first ovariotomy. Of how he had visited the patient, was satisfied that a tumor existed and was undecided about assuming the responsibility of its removal. Finally the patient herself urged that he should do the operation, recognizing that there was nothing before her but death if it was not removed. Finally he decided that he would attempt its removal and said, in thinking over his method of procedure, he knew perfectly well what ought to be in the abdominal cavity and proposed to open the abdomen and remove therefrom everything which did not properly belong within it.

Now that is what we propose to do in this patient today. My first step, after having carefully prepared and cleansed the patient, disinfected our instruments, cleansed our hands, in fact everything that is likely to come in contact with the patient, is to open the abdomen. In making the incision we cut through the skin, superficial fascia and aponeurosis in the median line, endeavoring to strike the linea alba or septum between the recti muscles. In a case in which the abdomen is but little distended, this is sometimes difficult, as it is not

more than one or two lines in width. I have opened the fascia upon one side over the muscle and as I pull upon the fascia I see the point of the linea alba and complete the incision through it. Having reached the peritoneum we now secure any bleeding vessels by hemostatic forceps. Generally where the bleeding is slight, it may be controlled by pressing the sponges for a moment firmly upon the tissues. The peritoneum is then picked up by two pairs of forceps and nicked between them with a knife. The peritoneal opening is extended the length of the incision. When it is separated I see a smooth, pearly, glistening surface which we at once recognize to be the wall of the ovarian cyst. Passing the fingers within the incision over the tumor, I find it is free from adhesions. We now plunge a trocar into it, when you see the thick, viscid material which escapes. The cyst is drawn out of the wound so as to avoid soiling the peritoneal cavity by its contents. My assistant is directed to place his hands on the abdomen above, making pressure down so as to push the cyst and its contents toward the wound.

In drawing up the cyst, watching for adhesions, we now lift it out of the pelvis and a second cyst which has completely filled it, and with this we recognize the reason why the cyst above was directed more to the left side, as it has evidently originated on the left side of the cyst within the pelvis. You see the right ovary, which has quite a long pedicle. As I am afraid of some of the contents of the cyst escaping into the cavity I will place on the pedicle a pair of forceps and cut off the cyst above it. In this way we have it out of our way and can now proceed to the next step of the operation, which is ligation of the pedicle.

The treatment of the pedicle is one which has caused a great deal of discussion. McDowell tied the pedicle with silk as was the custom in all wounds at that time and let the ends project from the wound. Nathan Smith used strips of kid carefully prepared, thus introducing the animal ligature. With the great work of Wells in Eng-

land was introduced the use of the clamp in place of the ligature, so that the pedicle was withdrawn from the abdominal wound, clamped and brought out, and placed at the lower angle of the wound. This resulted not unfrequently in unpleasant adhesions, in some cases in menstruation through the end of the Fallopian tube which projected from the end of the wound, and by a sloughing of the pedicle, rendering difficult the aseptic treatment of the wound. We will secure the pedicle by a double ligature, tying each half firmly so as to insure against the possibility of subsequent bleeding. For the ligature we have used silk which has been rendered aseptic by boiling and is as fine as can be used for this purpose. The finer the silk, the less trouble will it give subsequently. Having ligated the pedicle, removed the forceps and watched it to see if there is any bleeding, the ends of the ligature are cut short and the pedicle is dropped back. The next step in the operation, and one which you should ever keep in mind, is that the ovary must be examined, and if diseased, either the diseased portion or the entire ovary removed. In this patient we fortunately find the left ovary free from disease and return it. As the abdomen has not been soiled during the operation, we will not irrigate it. The parts are carefully sponged and a gauze pad is placed over the intestines beneath the wound, preparatory to the introduction of the sutures. The sutures of boiled silk are introduced, taking care to bring within their grasp all the tissues of the abdomen, and particularly important is it that the edges of the aponeurosis shall be brought in apposition. The sutures are introduced about one-half an inch apart, and about one quarter inch from the skin edges, one-eighth from the peritoneal edges. Each suture as it is introduced is secured by a pair of hemostatic forceps and after the introduction of the last suture we separate the wound, sponge its surface and then withdraw the gauze pad. It is important now that all the sponges shall be carefully counted so that it shall be impossible for the retention

within the peritoneal cavity of a sponge, otherwise one of these pads might be left to greatly increase the danger of the patient. The sutures are tied to one side of the line of incision.

We have not taken note of the time of the operation with the exception that the ether was begun eight minutes after twelve o'clock, and it is now twenty-five minutes of one. I do not speak of this as an indication that we have hurried in the performance of the operation, for I have endeavored to show you carefully the different steps of the procedure, and yet have not lost time, as the result for the patient depends somewhat upon the length of time she is under the influence of the anesthetic. The wound is dusted with a preparation of one part iodoform to seven of boracic acid, dressed with several layers of sterilized gauze, over which is placed a thick pad of sterilized cotton, covered by gauze. The dressing is held in place by tapes attached on either side by pieces of adhesive plaster and over all a scultetus bandage. The patient will be placed in bed, covered warmly; if she shows any sign of shock, will be surrounded by hot bottles, be given injections of normal salt solution to each half pint of which twenty-five drops of nux vomica are added. These will be used every four hours. We will give her no morphine, but if she suffers much distress will give an injection of chloral and bromide, thirty grains of the former to a drachm of the latter. Nothing will be given by the mouth until the stomach is quiet; after which she will be given hot water to allay her thirst, tea, coffee, broth, and after the third day, if everything is doing well, will be given a light diet, which will be increased from day to day. At the end of the week she will have a pretty fair diet. The dressing will not be changed unless something indicates it until the end of the week, when the sutures will be removed.

This operation has been an exceedingly easy one, indeed; I do not care to perform operations of this character frequently before the class for you will be led to suppose that ovariotomy is an easy operation and one that you need

have no fear to undertake. Many times the cases which you suppose will be easy afford some of the greatest difficulties that one can encounter in surgery. One of the greatest difficulties in the operation is the adhesions. These adhesions may be due to a variety of causes, to inflammation of the cyst wall, to pressure upon it, twisting of the pedicle, thus cutting off the supply of nourishment to the cyst, will lead to a loss of its vitality, which results in a chronic peritonitis and the formation of extensive adhesions through which the cyst is subsequently nourished. In dealing with adhesions we are governed, of course, by their character. Ordinary recent adhesions may be separated by the sponge and should always be done at the incision under the eye. The cyst wall is drawn upon and the sponge presses back the adherent viscera, practically sponging them off. Where the adhesions are firm, it may be necessary to use the scissors. If they are vascular, particularly of the omentum, ligatures should be applied. If they are short and very firm it is sometimes difficult to separate a coil of intestine, and it may be necessary to cut through the cyst wall, leaving a portion of it attached to the intestine. In such cases it is important always to remove the lining membrane of the cyst, its secreting surface.

In a case operated on some months ago, in Norristown, the cyst wall had to be cut through in a number of places, leaving a large portion attached to the intestine. The secreting surface was removed from all these pieces. After the cyst was removed the coils of intestine were separated by cutting through the portions of the cyst so that half a dozen patches of cyst were left within the abdomen. The patient recovered without an unpleasant symptom. The operation could not have been accomplished in any other way unless by resecting a large portion of the intestine.

In some cases the adhesions are firm between the parietal peritoneum and the wall of the cyst, so it renders it difficult to determine whether we have reached the cyst wall. In cases of

doubt we may determine by making our incision up to the umbilicus where all the layers of the abdomen are intimately connected, and from this point extend our separation. In difficult cases it is better to cut directly into the cyst than to attempt the prior separation. The adhesions prevent the peritoneal cavity from being soiled with the contents of the cyst. The cyst can be emptied, and then the hand passed into it, the posterior wall grasped, and withdrawn. In this way the parietal adhesions may be separated. Probably the most dangerous adhesions in elderly individuals are those of the pelvis.

The danger in these cases, a case occurring in my own experience a few years ago would well illustrate. The woman was over sixty years of age, had

**THE ALLEGED REFLEX CAUSES OF NERVOUS DISEASE.**—When a disorder or pain is not clearly understood it is too often put down as reflex in character and, as in the case of women, an operative attack on the genital organs is made. Dr. Philip Coombs Knapp is rather skeptical on the question of these reflex troubles and thinks that attention to some organ as the eye or uterus may help matters for a time but the cure is not permanent. He also thinks that such pain follows natural nervous channels and is not reflex. Quoting from his paper in the *American Journal of the Medical Sciences*, he says :

In these cases it is possible that the constant irritation of the sensory nerves, associated, perhaps, with the shock of an injury, may finally result in a motor discharge, giving rise to a pure reflex epilepsy. Such cases, however, are rare, and further investigation is necessary. The following conclusions seem justified :

1. The essential feature in the production of many neuroses is the neuro-pathic state—the degeneracy of the subject.

2. In hysterical subjects suggestion plays an important part both in the development and in the cure of the symptoms.

3. Disease of any organ may give rise

a thin walled ovarian cyst, which was emptied and an effort made to separate the adhesions in the pelvis. In slight traction upon the cyst wall, the pressure against the tissues led to a sudden discharge of dark blood, evidently venous. Notwithstanding the pressure we made with sponges, this filled the pelvis, the cyst was rapidly removed, the blood sponged out, the cavity packed with gauze, but the loss of blood was so great that the patient subsequently died. It was found that one of the large iliac veins had ruptured. Had I realized the gravity of the condition, the danger to the part, it would of course have been much better to have cut through the cyst wall, leaving a portion of it in place.

to referred pain in some definite area, but not to other nervous disturbances, except as a secondary result of local disease of the organ. This local disease manifests itself by the ordinary local symptoms, and the nervous phenomena are due to exhaustion, anemia, intoxications, etc.

4. In a few rare cases injury of a sensory nerve may give rise to epileptiform seizures.

5. Surgical operations for the relief of nervous symptoms should never be performed unless there are clear indications, apart from such symptoms, for operation.

\* \* \*

**PIANO PLAYING AND NEUROSES.**—A corresponding member of the Paris Academy of Medicine (*British Medical Journal*) has sent to that learned body a memoir in which he maintains that the numerous cases of chlorosis, neuroses, and neurasthenia observed among young girls is due to learning to play on the piano and the hours devoted to practicing. He has drawn up careful statistics from which he concludes that, among six thousand pupils obliged before attaining the age of twelve to learn to play the piano, nearly twelve per cent. suffer from nervous troubles. The author does not attempt to draw up statistics of the victims among persons who have to listen to their performances.

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BALTIMORE, NOVEMBER 9, 1895.

THE meeting of the State Society which is to take place on Tuesday and Wednesday, November 19 and 20, promises to be a very successful one and there is every prospect of a good attendance. The place of meeting is so accessible and the trains so convenient that there should be nothing to prevent every Baltimore physician attending both days even though they may wish to return in the evening.

The Committee of Arrangements has announced that the Rouse House will be headquarters for the attending members. The charges there will be one dollar a day or two dollars for the whole meeting. The railroad fare for the round trip is \$1.34 and the time on the Baltimore and Lehigh is one hour and a half. For those who care to use a wheel, the roads are fairly good and the distance in this way is about twenty-three miles.

The trains leave Baltimore for Belair as

follows: 8 A. M., reaching Belair at 9.30 A. M.; 9.30 A. M., reaching Belair at 10.50 A. M.; 4 P. M., reaching Belair at 5.25 P. M.; and 5.30 P. M., reaching Belair at 7 P. M. Returning trains leave Belair at 7.05 A. M., reaching Baltimore at 8.35 A. M.; 8 A. M., reaching Baltimore at 9.20 A. M.; 12.15 P. M., reaching Baltimore at 1.30 P. M.; and 4.30 P. M., reaching Baltimore at 6 P. M. This will give every one ample opportunity to be present at the sessions of both days or even one day. The majority of members will leave Baltimore Tuesday morning at 9.30 A. M., and the meeting will be called to order as soon as possible after the train arrives. It is hoped that the programme will be ready in time to publish in next week's issue.

Those who do not intend to read papers will find opportunities to enter into the discussions and make extempore remarks, and even those who assist the meeting by their presence only will find themselves repaid by this visit. The country all around Belair is varied and beautiful and especially at this season of the year the roads are good and the foliage is brilliant. The enthusiastic wheelman can take his machine with him and put in the time between the sessions in exploring the country around Belair.

Dr. Woods has already received titles of a number of papers, but those wishing it may possibly find an opportunity to read a short paper even though it be received too late to be announced on the programme.

\* \* \*

THE frequency with which temperance and prohibition congresses are held in English-speaking countries and the *Concerning Alcohol.* large number in attendance all show how important the drink question is, and probably no profession more than the medical profession sees the great harm which intemperate drinking does. It is probably because the physician, as a rule, is so familiar with the subject and also because in his training he has some experimental knowledge of the physiological effects of alcohol that he is, as a rule, less biased than his less well-informed fellow-men and women.

That the cause of temperance, total abstinence and prohibition in general has progressed there is no question, but it is a question if it has made progress in proportion to the great efforts that are honestly put forth

and to the time and money which is conscientiously but too often injudiciously expended. For example, it is a very questionable experiment to open a hospital which shall be conducted without the use of alcoholics of any kind and yet, if reports are correct, such a hospital has been opened, with what success remains to be seen.

The good women who are usually at the head of these great reforming movements have the most pure and well-meant intentions, but the enthusiasm peculiar to that sex too often shows the need of the regulating hand of the stronger sex. Sir Benjamin Ward Richardson stands almost alone as a man of particularly strong opinions on the subject of abstinence and yet a man whose scientific attainments demand universal respect and admiration.

Such reform movements should be directed toward all classes. The less educated mind can be influenced by stirring speeches and in a moment of fervid enthusiasm a promise to reform may be obtained, but the so-called higher class or those better educated must have their mind and common sense appealed to and this is attained much better by logical reasoning and moderate statements than extravagant expressions, which too often can be upset and thus defeat the very object for which they were intended.

The *British Medical Journal*, while in sympathy with the temperance movement, says, in commenting on this subject :

To ordinary readers the utterances, even of the more scientific of the speakers, suffer from the "cocksureness" which arouses a continual mistrust and leads us to suspect that, as science, their assertions are not worth all that their authors claim for them. It is of the essence of scientific truth that the searcher after such truth shall approach the study of natural phenomena with a single and unbiased judgment; whereas it is but too apparent that the total abstinence lecturer is disposed to seize upon such parts of current doctrine as are suitable to his purpose, and has little disposition to weigh those parts which seem against him. As advocates this way of dealing with truth is fair enough; we shall wait to reform our fellow creatures forever if we wait till scientific men work out a solid and coherent system of doctrine for us. Still, it would be more fitting if the speakers did not claim so loudly a scientific character for matter which is rather of the nature of counsel and exhorta-

tion than of scientific discovery or even of teaching.

\* \* \*

It is very satisfactory to note how the close relation between the apparently theoretical study of bacteria and the actual *Bacteriology* practice of medicine is gradually and *Practice* being recognized and admitted even by the most skeptical.

In the early stage of this new branch of pathology the practical mind, the utilitarian mind, anxious and impatient, wanted a prompt application of this branch to the practice of medicine and because it was not at once forthcoming many persons looked upon bacteriology as a fad that would soon die out. Those that grasped the subject from the start had always indefinite ideas of a great future for this branch of medicine, and now that one by one the practical uses of the study of germs are becoming evident, skepticism is giving way to admiration.

Dr. A. Alexander Smith, in an address delivered before the New York State Medical Association and published in the *Medical Record*, dwells on the practice of medicine in the light of bacteriological research, and while his remarks contain little that is not already well known to the reading man, still they bring together under one head about all that is known on this subject. His conclusions are that bacteriological researches have made clear many points in the etiology of diseases which before were obscure. It offers a satisfactory scientific explanation of the communicability of certain diseases. It has made diagnosis more definite, and in some instances aided in diagnosis which was impossible by any other method. It has led to more accurate prognosis. It has explained complications which before were considered accidental occurrences. It has revolutionized surgical and obstetrical practice. It has made it possible by intelligent sanitary surveillance to restrict and prevent the spread of dangerous epidemics. It has led up to the specific treatment of diphtheria (and possibly tetanus), and to conferring immunity for a longer or shorter period to those exposed to it.

A recognition of these conclusions brings the bacteriologist and clinician into most intimate relationship, each one as a necessary aid to the work of the other. The results of the work of the laboratory must be confirmed by the careful tests of the clinician.

MEDICAL ITEMS.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending November 2, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		26
Phthisis Pulmonalis.....		22
Measles.....	59	1
Whooping Cough.....		2
Pseudo-membranous Croup and Diphtheria }.....	20	5
Mumps.....	1	
Scarlet fever.....	18	
Varioloid.....		
Varicella.....		
Typhoid fever.....	18	6

The Hawaiian Island has a flourishing medical association.

At the last meeting of the Clinical Society of Maryland, it was unanimously voted to subscribe to one copy of the *Index Medicus*.

Dr. R. T. Gundry of Catonsville and Miss Katherine Hines, sister of Dr. W. Frank Hines of Chestertown, Maryland, were married in that place last month.

Dr. William H. Welch of Johns Hopkins University was the guest of the Philadelphia Medical Club, at a reception given in his honor at the Hotel Bellevue last month, which was largely attended by the principal members.

By the will of the late Mrs. Charlotte C. Gittings of Baltimore, the Union Protestant Infirmary will receive \$10,000, the Baltimore Eye, Ear and Throat Hospital \$4000, and the Church Home and Infirmary \$10,000, for the purpose of endowing a ward of five beds for cancerous affections.

At the last meeting of the Medical Society of the University of Maryland, held at the University October 15, 1895, the following officers were elected for the ensuing year: President, Dr. Randolph Winslow; Vice-President, Dr. Thaddeus W. Clark; Secretary, Dr. H. G. Utley; Executive Committee, Drs. John S. Fulton, K. B. Batchelor and J. Mason Hundley.

The Mayor and City Council of Havre de Grace, Maryland, have appointed a health

board for the city. The board will consist of Dr. H. S. Wenthoff, health officer, and S. J. Seneca, J. W. Foster, P. L. Hopper and Robert K. Vanneman, members of the board. The report that the city is affected with malignant diphtheria is greatly exaggerated. Two deaths only have been reported from this cause.

At the last meeting of the Tri-State Medical Society (of Iowa, Illinois and Missouri) the following officers were elected: President, Dr. Robert H. Babcock, Chicago; Vice-Presidents, Dr. A. H. Cordier, Kansas City, and Dr. W. A. Todd, Chariton, Ia.; Treasurer, Dr. C. S. Chase, Waterloo, Ia.; Secretary, Dr. G. W. Cale, St. Louis. The next meeting will be held in Chicago the first Tuesday, Wednesday and Thursday in April, 1896.

The Southern Surgical and Gynecological Association will hold its eighth annual meeting at Washington, D. C., November 12, 13 and 14, 1895. The following named are the officers elected for this meeting: President, Dr. Louis McLane Tiffany, Baltimore; Vice-Presidents, Dr. Ernest S. Lewis of New Orleans, and Dr. Manning Simons of Charleston; Treasurer, Dr. Richard Douglas of Nashville; Member of Council for five years, Dr. L. S. McMurtry of Louisville.

The Medical Society of the Presbyterian Eye, Ear and Throat Charity Hospital held its first regular meeting at the hospital building, 1007 East Baltimore Street, Baltimore, last Thursday evening. The following papers were read: "Some Muscle Cases," Dr. Hiram Woods; "Report of Some Mastoid Operations," Dr. Herbert Harlan; "Rhinitis Chronica Suppurativa," remarks upon some neglected causes of the same and their surgical treatment (new instruments), by Dr. John R. Winslow.

At the last meeting of the Clinical Society of Maryland held November 1, at the new hall of the Faculty on Hamilton Terrace, Baltimore, the following officers were elected for the ensuing year: President, Dr. J. Mason Hundley; Vice-President, Dr. William B. Canfield; Recording Secretary, Dr. H. O. Reik; Corresponding Secretary, Dr. W. Guy Townsend; Treasurer, Dr. W. J. Todd; Executive Committee, Drs. Wm. S. Thayer, S. K. Merrick and T. P. McCormick; Finance Committee, Drs. Wm. Green, Aaron Friedenwald and G. Lane Taneyhill.

## WASHINGTON NOTES.

The regular meeting of the Medical Society of the District of Columbia was held on Wednesday evening, the President, Dr. Samuel C. Busey, in the chair.

Dr. Swan M. Burnett presented a case and specimen of "Extraction of Cataract within the Capsule." The patient was present. The advantage of this operation is that the pupil is round and the preliminary iridectomy is dispensed with.

It was discussed by Dr. I. Bermann and Dr. E. Oliver Belt.

Dr. Metzerott read an interesting paper entitled "One Hundred Cases of Laryngeal Phthisis, treated with and without Operation." It was discussed at considerable length by Drs. J. H. Bryan, C. W. Richardson, T. Morris Murray, Isidor Bermann and James Dudley Morgan.

Dr. Francis P. Morgan read a paper on and presented photographs of specimens of Anhalonium Lewinii, giving the results of his experiments with this new drug, its physiological and therapeutic effects.

Dr. J. D. Bradfield presented a specimen of a very small fetus.

Dr. J. W. Chappell presented a post-mortem specimen of an Appendix. It had become adherent at its lower end to the intestine, thus forming a ring through which nine inches of the small intestine had slipped and become strangulated.

Dr. Taliaferro Clark has been appointed Physician to the Poor. He has been for several years Assistant to the Department of Nervous Diseases at the Emergency Hospital.

On October 30, 1895, the Post-Graduate School of Medicine of the District of Columbia was incorporated. A notice of its organization, with the names of the gentlemen forming it, appeared in a former issue of this JOURNAL. It is hoped that it will be a success. As its object is entirely for clinical teaching and as each gentleman connected with it controls an immense amount of clinical material in the different hospitals of the city, there is no reason why it should not come up to every expectation.

The Washington Obstetrical and Gynecological Society will hold a reception at the Arlington Hotel on November 12, for the entertainment of the Southern Surgical and Gynecological Society.

The Washington Obstetrical and Gynecological Society held its regular meeting on Friday evening, November 1, the President, Dr. George Byrd Harrison, in the chair.

Dr. G. Wythe Cook read an interesting paper entitled, "Some Disorders of Menstruation." It was liberally discussed by Drs. T. C. Smith, A. Behrend (visitor), A. F. A. King, George Byrd Harrison, F. S. Nash, Jos. Taber Johnson, E. L. Tompkins, H. D. Fry, George N. Acker and J. Wesley Bovée. Much of the paper and the discussion was directed to the fact that young girls were made to study too hard at school at or about the age of puberty, so that it was moved and carried that a committee should be formed, who would confer with the Commissioner of Education or other persons in authority and urge them to lessen the amount of study for these girls and thereby lessen the number of diseases and ailments that young women are now subject to, so many of which are so easily traceable to their school life. This Committee consists of Drs. J. Taber Johnson, A. F. A. King and G. Wythe Cook.

Dr. George N. Acker reported a case of an Artificially Fed Baby, which died and whose death was due to the parents not carrying out directions. This paper was discussed by Drs. W. P. Carr, Henry B. Deale and F. S. Nash.

The Society then adjourned.

## PUBLIC SERVICE.

## OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF MEDICAL OFFICERS.

## UNITED STATES ARMY.

*Week ending November 4, 1895.*

First Lieutenant Merritte W. Ireland, Assistant Surgeon, will proceed from Fort Stanton, New Mexico, upon the abandonment of that post, to Benicia Barracks, California, and report for duty at that station.

Captain William B. Banister, Assistant Surgeon, granted leave of absence for one month, to take effect on or about November 10, 1895, with permission to apply for an extension of one month.

## UNITED STATES NAVY.

*For One Week ending November 2, 1895.*

Surgeon M. H. Crawford and Passed Assistant Surgeon J. E. Page to the United States Steamship "Boston."

Passed Assistant Surgeon E. P. Stone and Surgeon G. P. Bradley to hold themselves in readiness for service on the "Indiana."

Passed Assistant Surgeon F. J. B. Cordeiro to the United States Training Ship "Constellation."

UNITED STATES MARINE SERVICE.  
*Thirty days ending October 31, 1895.*

R. D. Murray, Surgeon, granted leave of absence for 30 days, October 4, 1895.

Fairfax Irwin, Surgeon, granted leave of absence for thirty days, October 4, 1895.

C. E. Banks, Passed Assistant Surgeon, detailed as Chairman Board for physical examination of officers and candidates Revenue Cutter Service, October 2 and 8, 1895.

S. D. Brooks, Passed Assistant Surgeon, when relieved from temporary duty at St. Louis, Mo., to rejoin station at Chicago, Ill., October 3, 1895.

L. L. Williams, Passed Assistant Surgeon, to proceed from Charleston, S. C., to Waynesville, Ga., as inspector, October 2, 1895.

G. M. Magruder, Passed Assistant Surgeon, upon completion of duties at Camp Jenner, Eagle Pass, Texas, to rejoin station at Galveston, Texas, October 11, 1895.

J. O. Cobb, Passed Assistant Surgeon, to proceed to Victoria, B. C., and Vancouver, Washington, on special temporary duty, October 12, 1895.

B. W. Brown, Passed Assistant Surgeon, detailed as Recorder Boards for physical examination of officers and candidates Revenue Cutter Service, October 2 and 8, 1895.

E. R. Houghton, Passed Assistant Surgeon, granted leave of absence for thirty days from date of being relieved from duty at Vineyard Haven, Mass., October 5, 1895.

Emil Prochazka, Assistant Surgeon, when relieved from temporary duty at Charleston, S. C., to proceed to Cairo, Ill., for temporary duty, October 12, 1895.

A. R. Thomas, Assistant Surgeon, relieved from temporary duty at New Orleans, La., and directed to rejoin station at St. Louis, Mo., October 3, 1895.

J. B. Greene, Assistant Surgeon, relieved from temporary duty at Wilmington, N. C., and directed to proceed to Vineyard Haven, Mass., and assume temporary command of the Service, October 2, 1895.

E. R. Houghton, Passed Assistant Surgeon, resignation accepted, to take effect upon expiration of leave of absence, October 5, 1895.

George Purviance, Surgeon, granted leave of absence for twenty-five days, October 23, 1895.

W. H. H. Hutton, Surgeon, granted leave of absence for twenty days, October 19, 1895.

G. M. Guiteras, Passed Assistant Surgeon, granted leave of absence for thirty days, October 18, 1895.

G. B. Young, Passed Assistant Surgeon, relieved from duty in Laboratory of Bureau, and directed to rejoin his station at Key West, Fla.

Emil Prochazka, Assistant Surgeon, to proceed from Cairo, Ill., to Detroit, Mich., for duty, October 31, 1895.

CURRENT EDITORIAL COMMENT.

MUNICIPAL SANITATION.

*Memphis Medical Monthly.*

THE enormous benefit gained through sanitary improvements and organized effort to inculcate and enforce the observance of the principles of sanitation is so strikingly shown by the records of the Health Department of New York that it would seem as though a little study of the matter would suffice to make of every individual claiming to be civilized an enthusiastic, practical sanitarian.

PROFESSIONAL SECRECY.

*Physician and Surgeon.*

THE matter of professional secrecy has recently been commented upon to some extent in the home and foreign press, and it is asked, do doctors and lawyers invariably keep the secrets entrusted to them in their professional capacity? It seems to be generally admitted that they do, and it is at least satisfactory to believe that the maintenance of honor in regard to confidences is one of the commonest virtues. The doctor may be a quack, or the lawyer a shyster, and yet they do not as a rule betray confidences. Doctors as a rule are not gossips, and people have every reason for believing that the consulting room is like the confessional, a place from which no news ever issues.

LEISURE TIME.

*North American Practitioner.*

THE tendency with a vast number of young men, when once they are graduated, is to relax their efforts and to drift aimlessly along, taking kindly what comes to them, professionally or socially, unmindful of the peril of passivity. Thus many a man who made a splendid record as a student has failed to realize success as a physician. Genius alone will not assure it; nor will labor alone without genius. But a measurable amount of genius with work rightly directed will pretty surely win for one a way. But the work incident to success must not only be earnest and in the right direction, but it must be persistent until the end is accomplished. Every idle hour in waiting for business is an added opportunity. These hours, rightly used, cannot make him eminent in everything, but they can, sooner than he knew, render him eminent in some one thing.

# MARYLAND MEDICAL JOURNAL

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## ORIGINAL ARTICLES.

### ACUTE COCAINE-POISONING.

READ BEFORE THE PHILADELPHIA COUNTY MEDICAL SOCIETY, OCTOBER 9, 1895.

By M. V. Ball, M. D.,  
Philadelphia.

IN presenting this report of a case of acute cocaine-poisoning, I doubt whether I can offer anything new, and yet there are several interesting points to be noted. The literature on cocaine intoxication, though widely scattered, is, however, quite extensive. Mattison of Brooklyn and Germain Sée of Paris have each reported, in 1892, two hundred and more cases of poisoning, with twenty deaths. Since then quite a number of deaths have been recorded in medical journals. The dose at which fatal poisoning has occurred varied within marked limits. In five fatal cases reported by Manheim, the quantity of the alkaloid taken was over 15 grains. In two cases reported by Mattison, death occurred after the hypodermic injection of  $\frac{2}{3}$  grain. Symptoms of poisoning have set in when the drug was administered by the stomach, when thrown into urethra, nose, ear, rectum, or when injected under skin or into the gums; or when simply rubbed over the surface of the face. Absorption is very rapid, and in some of the cases reported the operator barely had time to withdraw the needle of his syringe before symptoms of intoxication set in. The symptoms described in each case differ greatly, and there are all stages, from slight incoherency in speech with dizziness and dilated pupils to excited hallucinatory delirium, thready uncountable pulse, convulsive breathing, or sud-

den collapse, or marked tetanic spasms. Cocaine poisoning exhibits the symptoms of strychnine-poisoning in some cases, in others that of alcohol, and in some a mixture of both.

I will now describe the case in question :

Mrs. C., aged thirty-five years, white, a sufferer for ten years past from rectal stricture, accustomed to use cocaine locally on pledget of cotton in the rectum, being tired of her existence resolved to end her life by swallowing 25 c.cm. (6 drachms) of 5 per cent. solution of cocaine, equal to about  $1\frac{1}{4}$  grammes ( $18\frac{1}{2}$  grains) of the alkaloid.

The dryness in the throat was speedily produced, and in attempting to get up from her couch to ring for the servant she felt dizzy and fell to the floor. A young medical student living in the house, and summoned at once, found her in a raging delirium. She wanted to throw herself from the balcony. She talked loudly, incessantly and incoherently. She was restrained by physical means, and when the student endeavored to give her a hypodermic of morphine she resisted, and would not allow him to do so; he persuaded her to take the tablets by the mouth, and so  $\frac{1}{3}$  grain was administered. It was about half an hour after that I saw the patient. She was held down on the bed by her friends, and was gesticulating wildly, yet was able to

recognize me as soon as I entered the room, appealing to me for help. I suffered her to be released, when immediately rushing past me she made for the open window to fling herself out. This she was prevented from doing, remarking, as she was led back to her couch, that after all "she wanted to look pretty when she died."

Her pupils were widely dilated, the pulse hardly perceptible and very frequent. The tongue would be protruded spasmodically, and teeth gritted together in a tetanoid manner. She talked incessantly. In a few minutes I was able to gain control over her without using physical restraint; and, though she talked irrationally at times, her delirium was less marked, and she told me that she was not going to get over the effects, nor would she allow me to give her an antidote; in the next breath she would ask me to listen to her singing or recitation. Frequently looking at her hands they appeared dirty to her, and she would rub them. Her tongue was much congested, bluish, anesthetic. Her throat was very dry; other parts of the body tested superficially gave no indication of anesthesia.

Respirations were normal. Temperature normal. Pulse, when counted, was 140. She stated that she felt glorious, never so happy before. Wanted to drink champagne, and when it was brought to her forgot that she asked for it. Delusions of persecutions were present to a slight degree, and her most intimate friend was accused of treachery and underhandedness. She was desirous of moving around, wanted to leave the house and visit a place she had not thought of for many years. Gradually a feeling of tiredness supervened, talk became less lively, bodily sensations were now complained of, and especially great thirst, which water or ice had no power to quench. Lemon and vinegar applied to lips was tasted, showing that sense of taste was not entirely absent.

Pulse still very frequent and small. Was able to administer black coffee, lukewarm water, and thus induce free emesis. At this time, which was two hours after the cocaine had been swallowed, the patient was resting quietly,

with her pulse stronger, but still rapid. Thirst was extreme, and in attempting to go to bath room she found her legs almost useless. The urine was passed. Strychnia, grain  $\frac{1}{30}$ , was administered by mouth, and some champagne was given. Perspiration started on skin, and the former pallid condition of face changed to a slight glow. Four hours after the initial onset the patient was sleeping soundly, and the pulse went down to 100, but was much stronger. Consciousness entirely returned, but no recollection of time and little of previous events, although she remembered when I came in. Next morning she was very weak, her body felt bruised, and her limbs heavy and almost useless. Feces and urine had been passed without trouble. No appetite. Tongue and throat still much parched, and thirst still present. Congestion of tongue was gone and normal sensation had returned.

A history of a previous overdose was obtained. The alkaloid in dry state was taken by mistake, and an active delirium much worse than the one just recorded occurred. Morphine was administered in large quantities at the time.

Very few cases are on record of recovery from so large a dose as the one taken in this case, although in a case where 22 grains were given by mistake by the mouth the patient died almost immediately. Forty grains have been taken daily by persons habituated to its use. And recovery would probably not have occurred were it not that patient was under the influence of the drug more or less for some time past. One of the earliest, possibly the first, cases of cocaine-poisoning is recorded by H. Ploss, in the *Zeitschrift für Medicin, Chirurgie und Geburtshilfe*, vol. ii, 1863.

Nieman, who was the first to isolate the alkaloid and give it the name it now bears, made known his discovery in 1859, but this fact was known to a certain apothecary, who was experimenting with coca leaves, and who, in 1863, thought he obtained a poison from them as fatal in its effects as strychnine. He took of this extract a considerable quantity with a view of ending his earthly existence, and while waiting for the

drug to take effect he joined some friends in a beer hall and indulged in a few mugs of beer ; he then retired to his bed and fell into sleep. Some three and a half hours after he took the poison he awaked with severe thirst and dryness in mouth, dizziness in head, and in attempting to walk across the room his legs gave way. He was unconscious then of what occurred until the morning, but from the appearance of his room he must have been rather active. In the morning he felt very weak, and still dry in the mouth and thirst. In the cases of poisoning that I have been able to collect, frequency of pulse, dilatation of pupils, convulsive twitchings of face and general convulsions, respiratory muscle spasm, unconsciousness, excited delirium, suppression of urine and cyanosis are the symptoms most common.

The delirium is to be distinguished from alcoholic delirium from the absence of frightful hallucinations. Hallucinations are rarely present. One, the so-called cocaine-bug, and which occurred in my patient, is believed by Erlenmyer to be due to disseminated scotoma. Spots of dirt seen on white surface ; as before noted in this patient, the fingers seemed black and dirty.

LeGrain states that the alcoholic tremor is wanting, but it was distinctly present in our case. The thirst and dryness of throat is a distinguishing feature. Otherwise, without a history, they seem very much alike. Moreno V. Maiz (*Recherches Chimique et Physiologique sur l'Erythroxylon Coca*, 1868) states that the thoughts are mixed up as in alcoholic intoxication. The phantasms are brilliant ; there is a flow of wit. I have seen in an advanced case of general paresis a similar delirium—a desire to sing and recite, to move about, to express a feeling of happiness. An habitué of cocaine has expressed himself as desiring rather ten years with cocaine than 10,000 centuries without it. The element of grandeur and personal aggrandizement sometimes enters. Dujardin-Beaumetz, in his *Dictionnaire de Thérapeutique Supplement*, 1895, states that the effects of cocaine in toxic doses in warm-blooded animals are similar to strychnine, but in cold-blood animals—

the frog, for instance—no convulsions are produced. It is like curare for the sensitive nerves, exciting the nerve trunks, and rendering the peripheral nerves analgesic.

François (*Arch. de Physiologie*, 1892, p. 562) finds it a paralyzing poison, not only on the sensitive fibers, but also on the motor and the fibers of muscles, as well as the protoplasm of cells. The frequency of pulse is probably due to paralysis of vagus ; the phrenic nerve is likewise interfered with, causing the respiratory spasms and tetanic arrest in some cases.

In my case there was no interference with the urine. The urine is often suppressed ; other secretions, as those of the mammary and submaxillary gland, have been noted as likewise affected by toxic doses. Maurel thinks that death is due to destruction of leucocytes. Their dead bodies collecting in capillaries and forming embolic processes. Reclus holds that thrombi form in veins, and when death occurs after an injection under the skin it is due to the penetration of a small vein. This will hardly account for the deaths happening after the drug has been thrown into the urethra or when swallowed by the mouth.

As to treatment, I cannot offer anything suggestive. Morphine has been looked upon as antagonistic, and has been given in the majority of cases recorded where symptoms of collapse are present early, with tetanic convulsions and cyanosis. Nitrite of amyl is indicated. Where heart's action is weak, stimulants, strychnine hypodermically, alcohol, ammonia and ether have all been suggested and tried. The early administration of  $\frac{1}{3}$  grain morphine did probably influence the course in the case described, but recovery is often rapid without any treatment. As the poison is eliminated rapidly by the urine and skin, the free action of these organs is desirable, especially as there is a tendency for them to be less active than usual. While the dosage of cocaine cannot be said to have any well-defined limits, several clinicians, among them Hänel and Decker, believe that  $\frac{1}{6}$  grain, hypodermically, should be the maximum dose.

## A CASE OF ESOPHAGOSTOMY FOR CICATRICAL STRICTURE.

READ BEFORE THE PHILADELPHIA COUNTY MEDICAL SOCIETY, OCTOBER 9, 1895.

By John B. Roberts, M. D.,  
Philadelphia.

A BOY, three and a half years old, had swallowed, three months previous to my examining him in December, 1894, a solution of lye, which resulted in stricture of the esophagus. It was said that a month before he came under my observation a rubber catheter could be passed through the contracted portion of the gullet. Upon examination I found the child greatly emaciated and very weak. I attempted to pass a flexible catheter down the esophagus, but even the smallest was arrested by a constriction at its upper part. A whale-bone filiform bougie, such as is used in urethral surgery, was, without much difficulty, however, pushed downward and apparently passed through the contracted portion of the tube.

As the child was evidently starving to death, I determined to operate upon him. My first intention was to do a gastrotomy. The bougie passed down the esophagus from the mouth would, I thought, have enabled me to draw a strong ligature from the stomach upward through the stricture. This would have been used to cut the stricture, as in Abbe's string-saw method. Careful examination of the patient, however, convinced me that the contraction was situated at a point sufficiently high to enable me to open the esophagus below it. I accordingly performed esophagostomy by making an incision along the anterior edge of the left sterno-mastoid muscle. I opened the esophagus a little below the level of the cricoid cartilage and introduced a No. 12 soft rubber catheter into the stomach. The edges of the esophageal wound were then stitched to the skin and the catheter allowed to remain for the introduction of liquid food into the stomach. There was some difficulty in identifying the esophagus, which was nec-

essarily small; because of the character of the lesion and the position of the thyroid gland. The left lobe of the thyroid gland extended to a higher level than the top of the larynx.

About half an inch above the first esophageal incision I made a second opening into the esophagus above the seat of constriction, and passed a rubber catheter upward into the mouth. Between these two openings the esophageal walls were largely cicatricial. I endeavored to dilate or lay open this portion of the tube, but was not successful. The point of a pair of forceps, introduced into what seemed the caliber of the esophagus, when forced upward passed backward behind the wall of the pharynx. The child's condition was so bad that I did not care to prolong the etherization while I endeavored to lay open or cut away the cicatricial tissue, and I accordingly determined to postpone further operation until the child could be nourished for a few days through the catheter used to convey liquid food into the stomach. The catheter which had been introduced into the portion of the esophagus above the stricture, and which protruded from the mouth, was withdrawn.

The child was fed on peptonized milk and stimulants in small quantities, but did not seem to rally well. On the tenth day a purpuric spot about four inches in diameter appeared upon the abdomen. This subcutaneous hemorrhage increased, the child became weaker and died on the sixteenth day. It was impossible to keep the seat of operation aseptic, because food and mucus contaminated the wounded surfaces notwithstanding the greatest care on the part of the nurse. Frequent washing of the part with mild antiseptic solutions was therefore maintained. The post-mor-

tem examination showed that about three inches of the esophageal walls were almost entirely destroyed by suppuration. This rendered it difficult to preserve the connection between the upper and lower portions during removal of the specimen. The bodies of the vertebrae at this point were exposed, and the inter-vertebral cartilages loose. Some of them could have been easily removed by picking them out with forceps. The spaces between the loosened cartilages and the bones were filled with a dark, foul-smelling pus. There was an area of consolidation about the root of the right lung, posteriorly; incision into this portion of the lung showed it to contain material similar in appearance, and of the same order as that in the region of the wound.

The life of this child could without much doubt have been saved if a surgical operation had been undertaken at the time it was possible to introduce a catheter through the constricted portion of the esophagus. The fact that I was still able to get below the seat of stricture at the time of operation makes me feel pretty confident that systematic dilatation, either with or without an esophageal opening made below the seat of stricture, would have permitted sufficient distension of the lumen of the tube

to have permitted successful feeding. The suppurative inflammation in the posterior mediastinum which occurred was largely due, I presume, to the difficulty of keeping the wound aseptic, and to the somewhat extensive disturbance of parts which I made in identifying and incising the esophagus at the bottom of the operative wound. This complication would almost certainly have been avoided if I had adhered to my original intention of opening the stomach and cutting the stricture by a stringsaw. It seemed to me, however, that there was less risk to the patient in making an opening in the cervical region into the esophagus, and cutting through the stricture by a string or other device. Curiously enough, however, after I had made the opening into the esophagus, I could not get the filiform bougie to pass through the strictured tissue and appear in the caliber of the opened gullet. It is possible that the filiform bougie, which I supposed I had passed through the stricture into the stomach two days before the operation, did not go down the esophagus. It may have perforated the wall at the stricture and entered the posterior mediastinum, being the real origin of the inflammation of the mediastinal tissues found at the post-mortem examination.

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## SPECIMEN OF CHYLURIA.

READ BEFORE THE PHILADELPHIA COUNTY MEDICAL SOCIETY, OCTOBER 9, 1895.

By F. P. Henry, M. D.,  
Philadelphia.

I AM indebted to Dr. Charles W. Coburn for this specimen of chylous urine, which I have the honor to present to the Society. The patient who voided it is a Cuban, aged forty-five years, from whom thus far but a meagre clinical history has been obtained. He has passed urine, such as is contained in this bottle, for the past two months and uninteruptedly; that is to say, that at no time during the period mentioned has the urine presented a normal appearance. Although his appetite is good, he has lost twenty pounds during the last three

months. These are about the only facts that I have been able to elicit concerning the man's present and previous condition.

You observe that the urine is absolutely opaque, and bears a sufficient resemblance to milk to render the term "galacturia," sometimes applied to such specimens, eminently appropriate. It has, however, a slightly pinkish tint, caused by the presence of a few blood corpuscles, and at the bottom of the bottle there are several pink coagula. A surgeon, to whom I showed the speci-

men this morning, took it for a solution of creolin, and it certainly resembles it very closely. The clots to which I have just referred must, I think, have been formed in the urine after its discharge, for there is no history of attacks of dysuria, such as might be expected to be caused by them, had they traversed the urethra.

As is well known, chyluria is generally associated with the presence of the filaria sanguinis in the blood, and this parasite has also been found in the altered urine. In fact, it was first detected in chylous urine by Wucherer, and, later, by Lewis in the blood of patients affected with chyluria. The animals discovered by these observers were minute nematode worms, about 0.3 mm. in length. They were subsequently ascertained to be the embryos of a much larger parasite, which was first detected by Bancroft. This adult animal is from 8 to 10 c.cm. long, and has been found in lymphatic abscesses, lymphatic glandular swelling, lymph-scrotum, etc. A most valuable addition was made to the life history of the parasite by Dr. Patrick Manson, of Amoy, China, who proved that the mosquito plays the part of an intermediary in conveying it from man to man. In the first place, Manson discovered that the embryonic filariae are detected with comparative ease in the blood of a patient who harbors them, provided such blood is withdrawn from the vessels of the surface during the night. At night the embryos swarm to the surface, while during the day they retire to the deeper vessels. Acting upon this knowledge, Manson exposed a patient affected with filariasis to the bites of mosquitoes and found the embryos in the bodies of these insects.

The mosquitoes, with the embryonic filariae in their interior, seek water in which to deposit their eggs. This function accomplished, they perish; the embryonic filariae are liberated, and through the medium of the water gain access to the human system. It is through the plugging of lymph vessels, especially those connected with the urinary tract, that the lymph gains access to the urine. Post-mortem examination

of those who have died from filariasis has revealed enormous distension of the thoracic duct and of the renal lymphatic vessels. In one case, that of Havelburg, there was found in the left hypogastric region a large sac with chylous contents, which communicated with the bladder.

There is, undoubtedly, a non-parasitic form of chyluria, caused by lymphatic obstruction from tumors or other causes interfering with the circulation of lymph. The commonest cause of such interference, however, is the parasite in question.

It is only fair to add that there are those who deny that the milky appearance of the urine in cases of chyluria is due to its admixture with lymph. The arguments in favor of this view are the following: In the first place, chylous urine does not contain sugar, which is a constant ingredient of lymph. Secondly, the quantity of fat in chylous urine is much greater than that contained in lymph; whereas, if derived from the latter source, it should be much less, since the urine normally is free from fat.

I have been unable to detect the filaria in this specimen. As regards the blood of the patient from whom it was obtained I have thus far seen but one specimen, and it was also destitute of filariae. The absence of the parasite cannot, however, be regarded as certain until after repeated and futile examinations of the blood. These, it is scarcely necessary to say, should be made at night—*i. e.*, at the time when the parasite comes to the surface.

Dr. Leffmann very kindly examined this specimen chemically, and, although he has not completed his study of it, I have his permission to announce the following results of his analysis:

The high speed centrifugal machine did not separate the fat. The latter was extracted by ether, and the ethereal solution on evaporation left a greasy deposit.

Trommer's test and the phenyl-hydrazine test gave no definite sugar reaction. Treating with a little acetic acid and heating in water-bath caused all suspended matter to collect in such

a way as to permit of complete filtration. The filtered liquid was pale yellow and perfectly clear. It was to the latter that the sugar tests were applied.

It is probable, from the readiness with which the suspended fat is entangled on heating with acetic acid, that a coagulable proteid is present.

## MAJOR OPERATIONS WITHIN THE NASAL CAVITIES.

READ BEFORE THE PHILADELPHIA COUNTY MEDICAL SOCIETY, OCTOBER 9, 1895.

By *Carl Seiler, M. D.,*  
Philadelphia.

FOR a number of years past, in fact ever since the introduction of cocaine as a local anesthetic in intra-nasal surgery, I have avoided as much as possible the employment of general anesthesia as cumbersome and unpleasant to both the patient and the operator; and in the majority of cases requiring but slight surgical interference and the performance of the minor operations, such as galvano-cautery, removal of polypi or ecchondroses, extirpation of the pharyngeal tonsil, and even straightening of the nasal septum, cocaine properly applied for a sufficient length of time before the operation I have found to answer all purposes. This local anesthesia has the inestimable advantage in these by no means simple or easily performed operations of securing for the operator the co-operation of the patient by not rendering him unconscious; the patient, thus being enabled to remain in the upright position, the usual one for examination, throughout the operation, can dispose easily and without inconvenience to the operator of any flow of blood, so that the operation need not be interrupted by any slight hemorrhage; and, what is of even greater importance, the topographical position of the parts in relation to the body of the patient, to the operator, and to the source of illumination remain the same as in ordinary examination of the nasal cavities, the knowledge of which relative positions, by long practice, has become, so to speak, automatic on the part of the operator, so that they are not consciously thought of by him during the operative manipulations if unaltered.

In those cases, however, in which the major operations within the nasal and

oral cavities, such as the removal of fibroid polypi in the post-nasal or nasopharyngeal cavity, of sarcomatous tumors, or of benign tumors invading the adjacent cavities, of necrosed bone in the posterior-nasal chambers, the extractions of large rhinoliths or impacted and incrusted foreign bodies, etc., are necessary, cocaine or any other purely local anesthetic is not applicable, because the site of operation cannot be reached with the cocaine solution, and because the extent of surface to be anesthetized is either too extensive or altogether unknown to the operator before the operation, and general anesthesia must of necessity be resorted to in order to keep the patient submissive and quiet, besides rendering the surgical procedure painless; under these circumstances it becomes necessary to place the patient in a recumbent position, which at once puts the operator at a disadvantage, because it in the first place alters the topographical relation of the parts to the operator, puts adequate illumination of the nasal cavities out of the question altogether or makes it extremely difficult, and, what constitutes the greatest objection, allows the blood to flow into the larynx and pharynx unperceived by the operator, and in such quantities as to endanger the life of the patient by suffocation if he is placed in the usual position — either on his back or on his side. This latter difficulty is usually obviated by plugging the post-nasal cavity, prior to the administration of the general anesthetic, if the operation is to be undertaken in either of the anterior nasal chambers, or by a preliminary tracheotomy and plugging of the superior laryngeal cavity, if the naso-pharyngeal

cavity has to be invaded during the operation, thus making it much more tedious and inconvenient to both operator and patient in the first instance, and in the second increasing the risk to life to a very great extent.

For a number of years past I have adopted a method which obviates the difficulty of blood running in the larynx and pharynx, and so does away with the necessity of preliminary tracheotomy or plugging of the posterior nares, and which has proved so efficient in a large number of instances that I feel justified in making public mention of it now that it has been thoroughly tested.

This method is very simple, and consists in placing the patient, after thorough anesthesia, upon the operating table, in a ventral recumbent position, with the head projecting, face downward, over the edge of the table.

The head is supported in a horizontal position by the hand of an assistant, and by placing a bandage around the forehead, the loose ends of which are secured to a band around the waist of the patient, or better still to a rigid support above the head of the table. In this position the flow of blood occasioned by the operation finds vent through the nostrils and mouth, and none of it finds its way into the larynx.

Of course, the topographical relation of the parts to the position of the patient is an entirely different one from that we are accustomed to in ordinary upright position, but not much more so than when the patient is in the prone

dorsal as lateral position, and with a little practice on the part of the operator this difficulty is soon overcome.

In order to obtain sufficient illumination an ordinary looking-glass or a concave reflector is placed upon the floor underneath the patient and secured in such a position that it will reflect light from any convenient source, a window or gas-jet, into the nasal cavities. As a rule, in such operations I depend upon the sense of touch rather than upon that of sight, but if it becomes *absolutely* necessary to see any particular portion of the nasal chambers, which can be seen during the operation, I adopt the very simple expedient of lying upon my back under the table, which brings me again into the same relation to the patient's nasal cavities that I was in when he was sitting conscious on the examining-chair, and thus the topographical relations are restored, under somewhat inconvenient circumstances it is true, to the normal and accustomed ones.

I have performed many of these *major* intra-nasal operations with the patient in the position described, and have been greatly pleased with not only the freedom of motion which it give to the operator for his manipulations, but also with the ease of mind and freedom from anxiety, lest blood should choke the patient in spite of all precautions to prevent such an accident, which have to be instituted in the old method of the dorsal recumbent position, even with the head extending beyond the edge of the table and hanging down.

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TREATMENT OF HERPES ZOSTER.—Dr. L. Weiss of the New York Post-Graduate Medical School writes: The treatment will consist of constitutional and local measures; the former based upon general principles, the latter to allay local pain. Do not use fatty salves which form an impermeable cover on the hot and inflamed surface, but use a cooling salve, the prototype of which is our cold cream. The water contained in it promotes evaporation and cools the parts. Mix ten per cent. cocaine with

it. Dusting powders, especially in the form of a small bag filled with it and tied to the parts, act beneficially. I have found that methyl blue applied to the sores accelerates healing. You may administer it internally also, in capsules of one-half grain each. A blue discolouration of the urine will follow, which is of no consequence. Against the lancinating pains you may try the galvanic current, but a hypodermic injection of morphine will prove a more ready standby in most cases.

**SOCIETY REPORTS.****PHILADELPHIA  
COUNTY MEDICAL SOCIETY.**

MEETING HELD OCTOBER 9, 1895.

*Dr. M. V. Ball* read a paper entitled ACUTE COCAINE-POISONING. (See page 73.)

*Dr. Thomas J. Mays*: I was much pleased to listen to this report of a case of cocaine-poisoning; in fact, I have always been much interested in the toxic effect of cocaine, especially in regard to the question whether cocaine causes convulsions in animals from its influence upon the peripheral or upon the central nervous apparatus. Dujardin-Beaumetz says that in the frog cocaine convulsions never occur and that there is a strong analogy between cocaine and curare, one acting upon the sensory and the other upon the motor filaments. In warm-blooded animals all are agreed that convulsions do occur. I think too much stress is laid on the complete absence of convulsions in the frog when poisoned by cocaine, for I have certainly seen general convulsions precede the paralytic stage, although they are of short duration. It has been observed that while small doses of strychnine cause convulsions in frogs, large doses do not—the frog lying on the table just as if he were poisoned by curare or by cocaine. I have performed many experiments in this direction, but found nothing new so far as the action of cocaine is concerned; indeed, the more you experiment with cocaine the more confusing its action seems to become. While small doses produce tetanic symptoms, there is, I believe, a case on record in which sixteen grains were said to have been given without any bad results. Cocaine, like strychnine, theine, and curare, arrests the heart in diastole in the frog, while other alkaloids, delphinin, for instance, arrest the heart in systole. It is very strange that cocaine should resemble those alkaloids so greatly in some of its effects and yet differ so much in others.

*Dr. John B. Roberts* related a CASE OF ESOPHAGOSTOMY FOR CICATRICAL STRICTURE. (See page 76.)

*Dr. L. J. Hammond*: I would like to ask Dr. Roberts if he found at the post-mortem any dilatation of the esophagus below the stricture, a condition which would be expected to result from lack of use, also from interference to the blood supply? I would also ask whether it would not have been possible to do a combined esophagostomy, first making an external incision into the esophagus and then introducing an instrument from below and sever the stricture?

*Dr. W. D. Robinson*: I recall a case which I saw in the Eastern State Penitentiary some years ago, in which a stricture of the esophagus near the stomach had existed for some years, and had in the last few months grown so tight that dilatation was decided on. At the time we were about to operate we were called away from his cell for a few minutes to finish some final preparations. During this short interval the man was taken suddenly ill and we were hastily called to him and found him moribund from hemorrhages into the stomach. The autopsy revealed an extensive cancer of the esophagus which had opened an artery, filling the stomach with blood. Had this bleeding not occurred just when it did, it would certainly have been decided by any attempt to pass a dilating instrument, which would have been tried in a few minutes.

*Dr. S. Solis-Cohen*: I would ask Dr. Roberts if, with his present knowledge of the case, he still thinks that gastrostomy would not be preferable to the operation which he did?

*Dr. Roberts*: I think that it might possibly have been better to have opened the stomach. But in this case the esophagostomy was one of unusual difficulty; the thyroid gland was large and the left lobe extended beneath the cricoid cartilage. My original intention was to open the stomach and then cut the stricture by Abbey's method, by passing a fishing cord through the stricture from below and see-sawing the cord through the cicatricial tissue.

*Dr. F. P. Henry* exhibited a SPECIMEN OF CHYLURIA. (See page 77.)

*Dr. S. Solis-Cohen*: I presented a case to this Society several years ago,

which was examined by Professors Joseph Leidy, Angelo Heilprin and others beside myself. In that case repeated examinations failed to detect evidence of the parasite in the blood or urine. The patient was a colored boy who came from one of the West India Islands, who had had previous attacks in which, as in the one referred to, the chyluria subsided spontaneously.

*Dr. M. V. Ball:* I examined some of this urine but without finding the parasite. On letting the specimen stand over night, the urine separated into two portions, a fatty material sinking to the bottom of the vessel. The specimen seemed filled with shreds, which when spread out on a cover-glass resembled chipped beef more than anything else.

*The President:* Some years ago I had the opportunity of seeing a similar case. A young, highly anemic girl passed urine at times normal, at times chylous. Repeated examinations of the urine and examinations of the blood at night failed to show any parasite. The patient afterwards completely recovered and has not since passed urine of that kind.

*Dr. Carl Seiler* related a NOVEL METHOD OF OPERATING FOR MAJOR OPERATIONS WITHIN THE NASAL CAVITIES. (See page 79.)

*Dr. E. L. Vansant:* I think that the experience of Dr. Seiler in the use of cocaine in the smaller operations upon the nose and in the naso-pharynx is that of all observers and operators in this line of work. I agree with him also in the necessity of using a general anesthetic in the larger operations in these regions. I will go further and say that I like to give a general anesthetic for operations for marked deviations of the septum and for the removal of adenoid growths from the rhinopharynx; because I think that the operations are more thorough and the results are more satisfactory than when no general anesthetic is used, and because I am convinced that, as a rule, if the results are not satisfactory after operation it is because the work was not thorough enough. If such operations are done under cocaine, you may

find the patient becoming faint from loss of blood or presenting nervous symptoms which may compel you to desist before you have completed your operation. As regards the new method of intra-nasal operating referred to by Dr. Seiler, it does not strike me that there is anything especially useful in placing the patient face downward and holding the head, as described by Dr. Seiler. I have found that with the use of the mouth-gag and having the patient's head extended backward and held over the end and side of the operating-table, that the blood will generally run out of the nose and into the naso-pharynx, and the patient continues to breathe through the open mouth. I must confess that I have had no experience in lying upon my back to operate, and I think that this portion of the paper makes a suggestion which may certainly be called novel. When the head is held, as described by the lecturer, I should think that difficulty would arise with the respiration, owing to the constrained position, and that continuing administration of an anesthetic would be almost impossible. It is better under such circumstances to rely upon the sense of touch rather than to attempt to follow the operation with the eye, and this is the course that is generally followed.

*Dr. G. G. Davis:* It is hard to determine the value of a new procedure, unless it is seen in the hands of those who advise it. I have never seen any operations done by the method proposed and practiced by Dr. Seiler; but it may be in some cases valuable. The usual method of operating in cases where blood is likely to flow into the larynx is to resort to the hanging-head position of Rose. The patient lies upon his back with the head hanging over the end of the table. The blood flowing into the pharynx may be removed by sponges, or by some form of suction apparatus. When we consider the method of operation proposed by Dr. Seiler, if the object is to prevent the blood from entering the larynx it is evident that this can be accomplished as well by the hanging-head position. The ob-

ject of Dr. Seiler's method is to enable the surgeon to see what he is doing. In operations of this kind the field is so soon covered with blood that it is soon obscured, and the operation must be carried on mainly by the sense of touch. In operations for cleft palate, it is necessary to have a view of the parts; but ordinarily the operating on the nasal cavities is done by the sense of touch alone. There also comes up the question of keeping up the anesthesia by this method, as in some patients the ventral position interferes with respiration so much as to make it inadmissible. In cases where it is necessary to give chloroform, particularly, such interference with respiration would be very dangerous.

It is so difficult to obtain a sight of the nasal chambers while operating in them that it is doubtful if it can be accomplished, even by the operator lying down upon his back, as Dr. Seiler has proposed; it would require an exceedingly nice adjustment of angles to avoid the blood dropping down vertically, while at the same time illuminating the parts with the mirror. The difficulties are so great that they lead me to prefer the hanging-head position. Where it is absolutely necessary to see, or have better access to the parts, then the method of Nélaton, of splitting the palate, or that of Rouge, of separating the soft parts and turning them up, is preferable.

*Dr. John B. Roberts:* I have been much interested in Dr. Seiler's communication; but think with Dr. Davis that the dropping of blood, and perhaps the patient vomiting at the same time, would make it unpleasant for the operator. The ordinary method of allowing the patient's head to hang backward over the pillow causes the blood to flow downward along the pharyngeal wall, and it does not enter the larynx; it enters the stomach and is digested or vomited. These operations are all bloody, so that we often have to proceed by touch rather than by sight; but with the head in strong extension, so that the blood will flow into the pharynx and be swallowed, no special danger

from strangulation by laryngeal obstruction need be anticipated.

*Dr. Carl Seiler:* I see that my little suggestion shares the fate of anything that is brought forward out of the ordinary run. As soon as anything is offered that is novel it is criticised and frowned down on account of theoretical objections; but this is only what I supposed would occur. Now, to take up the objections made, I will say in reply to the first speaker, that he did not take into consideration what I mentioned at first, which was that this method was only applicable in major operations. Nor did he take into consideration that I am not quite so hide-bound as to consider it applicable to all cases—the operation must be suited to the case. The other speakers criticised the necessity of viewing the field of operation. I only say that in cases where it is absolutely necessary to have a view, I adopt this method. I do not lie upon my back all the time; that would be absurd. At the Milwaukee meeting of the American Medical Association, in discussing a paper by Dr. Farnham, I said that any surgeon who will injure the external integument of the face, except where it is necessary to the operation, as in the removal of a sarcoma or other growth, does a criminal act, and therefore Nélaton's method is a criminal operation.

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#### COLLEGE OF PHYSICIANS OF PHILADELPHIA.

##### SECTION ON OPHTHALMOLOGY.

A stated meeting of the Section on Ophthalmology was held in the Lower Hall, College of Physicians of Philadelphia, on April 16, 1895, Dr. Wm. F. Norris, chairman, presiding. Present, Drs. Fenton, Hansell, Harlan, Norris, Oliver, Randall, Risley and Stahl, Fellows of the College, and Drs. Archer, Cassell, Cummings, Murphy, Pancoast, Perrine, Seaman of Milwaukee, Schwenk, Stevens and Ziegler as guests.

*Dr. George C. Harlan* showed a case of irideremia in a 24 year old colored woman, in which there was the usual cataractous condition of the lenses. He

stated that it was his purpose to endeavor to better vision by needling. In answer to an inquiry by Dr. Randall, whether the case presented any hereditary taint of a similar nature, Dr. Harlan asserted that no such influence could be found in this instance.

*Dr. Wm. F. Norris* reported a case of leuco-sarcoma of the choroid producing secondary glaucoma, and made some remarks upon the preservation of the specimen in formol. Examination showed that the pressure symptoms had advanced sufficiently far to give rise to a pathological excavation in the optic nerve head. As regards formol, he stated that although the drug produced a marked shrinkage in the specimen, yet the great advantage that this material possesses over other preservatives was that the tissues were not stained nor discolored. He had found that most excellent sections could be prepared in four or five days after the first immersion.

*Dr. Charles A. Oliver* made some remarks upon a case of essential atrophy of the conjunctiva and showed a water color sketch of the external condition. He desired to place this special type of case upon record on account of its extreme rarity.

*Dr. S. D. Risley* read the notes and exhibited a sketch of opacity of the cornea simulating lead deposit. The case was of extreme interest as having given a definite history of the prolonged and continuous use of a solution of acetate of lead. Careful analysis made by a competent chemist failed to reveal any trace of any salt of lead.

*Dr. Harlan* asked, in view of the fact that there were so many reported cases of clinical evidence of lead depositions, whether there were any instances in which chemical examination revealed the presence of lead in the opacity?

*Dr. Risley* stated, in answer, that he had not found any in the literature at his command.

*Dr. Harlan* exhibited a case of embolism of the central retinal artery, in which a large hemorrhage appeared during examination.

*Dr. Risley* spoke of having seen a case of retinitis albuminurica in which, while

the patient was sitting in his office being examined, a bright red hemorrhage appeared in the lower part of the fundus. This increased in size, while he was looking at it. After instillation of cocaine into the eye, so as to better observe the condition, he had full opportunity to watch the blood spread over a large portion of the lower part of the fundus as a thin membranous veil. He watched this extravasation of blood at intervals for several weeks' time. The eye-ground showed numerous other striated hemorrhages and plaques that are so characteristic of albuminuric retinitis.

*Dr. Hansell* stated that although never having seen the actual appearance of such hemorrhages, yet he had frequently seen cases in which fresh extravasations had appeared during the intervals between the daily examinations.

*Dr. Norris* noted an unusual case which had come under his observation some years previously. The patient, a middle-aged woman, while sitting in church, noticed the appearance of a reddish black spot before her eye. Examination upon the following day showed the presence of a large fresh hemorrhage, which covered the entire macular region and extended into the vitreous. The extravasations gradually disappeared and vision returned to normal. *Dr. Norris* stated that the interesting point in this case was the fact that the patient began to lose her sight when she was not making any special physical exertion.

*Dr. Fenton* stated that he had had the opportunity of twice noticing the onset of retinal hemorrhages in a case of albuminuric retinitis which was under his repeated observation for several hours daily for sixteen days. He also called attention to the fact that he had frequently observed the appearance of fresh hemorrhages after intervals of a few hours.

*Dr. Oliver* gave a blackboard demonstration of two cases of subconjunctival dislocation of the lenses, occurring in the same week. Both lenses were removed and the eyes were fast becoming quiet and well, with recovery of useful vision. To an inquiry by *Dr. Harlan*

whether the capsules were ruptured in these instances, Dr. Oliver said that they were not.

*Dr. Norris* stated that he possessed a specimen of such a dislocation of the lens in which it could be plainly demonstrated that the capsule was intact.

The Section then went into executive session. Upon motion adjourned.

CHARLES A. OLIVER,  
Clerk of Section.

### MEDICAL PROGRESS.

**INSANITY AND PHthisis.**—Dr. H. A. Tomlinson, Superintendent of the St. Peter State Asylum in Minnesota, was led by a paper of Dr. Thomas J. Mays of Philadelphia to look up the subject of the transmutation, concurrence and co-existence of insanity and phthisis. His paper, which was read before the American Neurological Association and published in the *Journal of Mental and Nervous Disease*, is very exhaustive and very thorough. As a result of this study he says : 'The intimate association between phthisis and insanity, however, is certainly significant, and the observations I have made could undoubtedly be paralleled in any institution for the insane. The weak point in the paper is my inability to present a similar series of observations of the nature of the changes found in those dying of phthisis who are not insane, and I have not been able to find anything bearing upon the subject from this standpoint, with which to compare my observations. The points especially requiring explanation are the infrequency of insanity among victims of phthisis and the nature of the hereditary conditions in these cases. It is certainly a fact that many cases of phthisis, who do not become insane, show some of the stigmata of degeneration, but I am debarred from studying this part of the subject in detail. I hope, however, that the subject as I have presented it will interest some of you who may have this opportunity, for I am growing more and more confident that the pathology of insanity will only become clear when we fully understand the nature and causes of defective development.

It also seems to me highly probable that, aside from the asymmetry and undue or imperfect development of the external parts of the body, we have as the principal characteristic of somatic degeneration, excessive growth of connective tissue ; while in the higher form of instability or irregular development, the most marked characteristic is excessive development of highly unstable functional tissue easily disintegrated and of limited potentiality, with connective tissue increase as a secondary manifestation.

\* \* \*

**GOITER AMONG THE AMERICAN INDIANS.**—Dr. Edward I. Munson of the United States Army, while serving in Montana, noticed the frequency of the occurrence of goiter among the Indians. He studied the different tribes in that part of the country and from his work as published in the *New York Medical Journal* he brings out the following salient points :

That there is a strong racial predisposition to goiter among the Indians.

That goiter is a distinctly localized disease.

That goiter does not appear to be caused by the high altitude, climate, or water containing an excess of calcium salts.

That this disease appears to be favored by unsanitary surroundings, depressing constitutional conditions, and an improper and excessively nitrogenous diet.

That hereditary influence is a prominent factor in the causation of this disease.

That sex and puberty exert strong influence in its production, and that there appears to be an intimate relationship in women between the thyroid gland and the reproductive organs.

That cretinism is extremely rare in connection with this disease, and exophthalmic goiter moderately so.

That the tumor is correspondingly smaller than among the whites, and that localities apparently affect the growth of the tumor as well as its frequency.

That the usual treatment is unsatisfactory.

MARYLAND  
**Medical Journal.**

PUBLISHED WEEKLY.

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BALTIMORE, NOVEMBER 16, 1895.

THE Committee of Arrangements for the semi-annual meeting of the State Society at Belair has provided a very full and varied programme. The specialties are well distributed and general medicine has not been neglected.

Besides the address of welcome and the president's remarks, there are nineteen papers down and it is very pleasing to note that the physicians of Harford County contribute three of them. It is hoped that as many as possible will be present and by their interest and discussions give the meeting that success which it deserves.

A banquet and informal reception will be held on Tuesday night. The meeting will open Tuesday morning at 11 o'clock, immediately after the arrival of the train, leaving Baltimore at half-past nine. The time table of trains and the rates of the hotel were published last week.

The programme is as follows: First day, morning session, 11 A. M.: Address of Welcome, Dr. W. L. Smith, Belair; President's Address, Dr. J. Edwin Michael, Baltimore. Papers: 1. The Surgical Treatment of Laryngeal Tuberculosis, by Dr. J. N. Mackenzie. 2. Notes on Treatment of Iritis, by Dr. Harry Friedenwald. 3. Utero-Vesical Fistula, by Dr. T. A. Ashby. 4. Tears of the Cervix Uteri; Their significance and Repair, by Dr. J. M. Hundley. Adjournment at 2.30 P. M. Afternoon Session, 3 o'clock P. M. 5. The Cause of Death in Chronic Diseases, by Dr. Simon Flexner. 6. An Epidemic of Typhoid Among Children, by Dr. A. K. Bond. 7. The Lessons of the Present Epidemic of Typhoid Fever, by Dr. Wm. Osler. 8. The Action of Saliva in Gastric Digestion, by Dr. Julius Friedenwald. 9. Wounds of the Kidney, by Dr. I. R. Trimble. 10. Report of Some Cases, by Dr. W. W. Virdin. Adjournment at 5 P. M. Second day, Wednesday, November 20, morning session at 9.30 A. M. 11. Management of Advancing Corneal Ulceration in Gonorrhreal Ophthalmia, by Dr. Hiram Woods. 12. A Critical Review of Modern Operations for Hemorrhoids, by Dr. S. T. Earle. 13. Practical Treatment of Strangulated Hernia, by Dr. Silas Scarboro. 14. Report of Some Recent Cases of Abdominal Injuries, by Dr. R. Winslow. 15. Report of some Cases, by Dr. J. H. Kennedy. Adjournment, 12 M. Afternoon session, 1 P. M. 16. The Clinical Course of 47 Cases of Complete Extirpation of the Uterus for Carcinoma, by Dr. W. W. Russell. 17. Primary Tuberculosis in Relation to Otitis Media, by Dr. E. J. Bernstein. 18. Recent Advances in the Histology of the Nervous System, by Dr. George J. Preston. 19. Purulent Rhinitis, with Especial Reference to Chronic Empyema of the Ethmoidal and Sphenoidal Sinuses, by Dr. J. R. Winslow.

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THE condition of the urine in ordinary cases of acute nephritis is very easily made out with the simplest tests, but Dr. John A. Lichty points out in the *Medical News* that some very necessary facts are frequently overlooked in the hurried examinations usually made by the busy physician.

Physiologists mention some ten or twelve causes of albuminuria, yet on looking them

over the underlying cause seems to be some disturbing irritant in the kidney or other part of the urinary tract. A case should not be called one of physiological albuminuria until a nephritis can be positively excluded. In examining the urine, aside from the more common points to be observed, four facts should be emphasized.

1. A continued low specific gravity must be looked upon with grave suspicion, until it can be proved beyond a doubt that the kidneys are normal. When the specific gravity is below 1015° it is necessary to consider diabetes insipidus. A careful search for casts must be made and a centrifuge here is of great assistance.

2. In nephritis during the greater part of the disease it may be impossible to detect albumen or casts. This may be because that part of the kidney involved is almost entirely effaced functionally, while the normal part carries on the work and it is only after a fresh cold or indiscretion in diet that extra strain is thrown on the kidney and while the worn out part is trying to do its former work, albumen and casts appear.

3. Casts may be present when it is impossible to detect the presence of albumen. In this case there is marked polyuria but not enough casts present to cause albuminous precipitate.

4. Urine should be examined as soon as it is passed. Bacteria and fermentation destroy casts quickly. The centrifuge should always be used. The urine should be examined at regular intervals, just as the teeth are examined by a dentist, and especially should it be examined during and after any serious illness.

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IN an accident or emergency when a physician is needed, there are many found willing

to summon him but few

**Liability for Fees.** think of the responsibility involved. A physician is human in not wishing to see one of his fellow-men suffer when aid is at hand, but a physician is also human in that he must live, and his stock in trade, his capital, so to speak, is, in part, his ability to help in sickness, in an accident, in an emergency.

The laborer is worthy of his hire and therefore he that summons a physician or he that receives his help, should not, when danger is

past, and relief has come, ignore all demands for payment and repudiate a just bill. If a physician's services are received by a person it is an implied contract to pay reasonable and fair return for this service.

In the case of railway accidents, physicians are often called in an emergency to render aid to those injured whether of the crew or passengers. There are cases in which the company is responsible to the physician for the services rendered and yet how ready a corporation is to refuse to pay a debt of this kind, probably in part because impositions are so often attempted on corporations.

In the *International Medical Magazine*, Lorenzo D. Bulette, Esq., of the Philadelphia Bar, quotes an opinion of Mr. Justice Elliott of the Supreme Court in the case of a railroad accident at a point on the line distant from towns and where the service of a surgeon of the company could not be obtained. In this case a brakeman was injured and the conductor, the superior officer in charge, summoned the nearest physician, who promptly rendered service and sent in his bill, which the railroad company at first would not allow, but which the court afterward decided the railroad company must pay.

It is well to have such questions settled once for all. No physician would refuse to help at an accident simply because he was uncertain of his pay, but in all such cases the physician owes it to himself, to his family and to his creditors, if he has them, to find out as soon as possible after being called to an emergency case who is responsible for his bill, and if no one will assume this, then he should withdraw as soon as all danger is past and in case one of his colleagues should succeed him in the case he should be made acquainted with the facts. This is not mercenary; it is an act of justice to the whole profession.

Physicians always give their time and skill willingly and when payment is refused they too often have no redress or are too honorable to take any decided steps to collect their dues. Such decisions should be proclaimed far and wide and the words of the judge should be a precedent upon which all future decisions of this kind should rest.

Physicians are always ready to render charity where it is deserving; how much less, then, should they expose themselves to imposition from those able to pay.

**MEDICAL ITEMS.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending November 9, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		23
Phthisis Pulmonalis.....		36
Measles.....	74	
Whooping Cough.....		
Pseudo-membranous Croup and Diphtheria. }	19	7
Mumps.....		
Scarlet fever.....	11	
Varioloid.....		
Varicella.....	2	
Typhoid fever.....	16	8

Dr. Robert Battey of Rome, Georgia, whose death was prematurely announced about a month ago, died last week after a lingering illness.

The new Governor of Maryland and the new City Council and Mayor of Baltimore will have several good positions to bestow on physicians.

The first revised edition of Osler's Practice of Medicine was taken by the trade as soon as it appeared. The publishers are printing another edition.

Dr. X. O. Werder has been elected Professor of Diseases of Women in the Western Medical College in succession to Dr. W. J. Asdale, resigned.

Reports to the supervising surgeon general of the United States Marine Hospital Service indicate that during the present epidemic of cholera in Japan there have been 42,706 cases and 28,513 deaths.

Dr. Richard B. Fruit, a prominent physician of Hazleton, Pa., a graduate of Jefferson Medical College in 1854, died last week, aged 68 years. Dr. Fruit was president of the local board of health.

By the will of the late Captain Lang of Gardenville, Baltimore County, Maryland, the St. Joseph's Hospital of Baltimore will receive more than \$300,000, unless the will should be broken by relatives.

The William F. Jenks Memorial Prize of the College of Physicians of Philadelphia for 1895 has been awarded to Dr. Abram Brothers

of New York, for an essay on "Infant Mortality During Labor, and its Prevention."

The Alvarenga Prize of the College of Physicians of Philadelphia for 1895 has been awarded to Dr. Guy Hinsdale of Philadelphia, for an essay on "Syringo-myelia."

*Pediatrics* is the name of a new special journal ; Dr. Dillon Brown of New York is the owner and Dr. George A. Carpenter of London, the editor, with an editorial staff from England and America. It is published semi-monthly. The cover page is very artistic.

The following is the programme of lectures at the Royal College of Physicians for the coming year : The Goulstonian Lectures will be delivered by Dr. Patrick Manson ; the Lumleian Lectures by Sir Dyce Duckworth ; the Croonian Lectures by Dr. George Oliver in 1896, and by Dr. Greenfield in 1897. The Bradshaw Lecture was delivered by Dr. Bradbury on November 7, 1895.

At the last meeting of the American Orthopedic Association the following officers were elected : President, Dr. Royal Whitman of New York ; First Vice-President, Dr. George W. Ryan of Cincinnati ; Second Vice-President, Dr. Joel E. Goldthwait of Boston ; Secretary, Dr. John Ridlon of Chicago ; Treasurer, Dr. E. G. Brackett of Boston. Place of next meeting, Buffalo ; time, third week in May, 1896.

The New York Obstetrical Society has elected the following officers for the year 1895-1896 : President, Dr. Henry C. Coe ; Vice-Presidents, Drs. J. Riddle Goffe and A. Palmer Dudley ; Recording Secretary, Dr. Arthur M. Jacobus ; Assistant Recording Secretary, Dr. George W. Jarman ; Corresponding Secretary, Dr. Robert L. Dickinson ; Treasurer, Dr. J. Lee Morrill ; Pathologist, Dr. George C. Freeborn.

A gastro-enterological society has been formed in Baltimore, the object of which is a study of diseases of the stomach and intestines. The meetings are held the third Saturday of each month. The proceedings consist of a paper which must give evidence of original research, the exhibition of cases and a survey of the literature of the subject for the past month. An address is delivered annually by some eminent specialist. The society would like to hear of all physicians everywhere who are interested in this subject.

## WASHINGTON NOTES.

## PUBLIC SERVICE.

The Incorporators of the Post-Graduate School of Medicine of the District of Columbia met on the evening of the 5th of November at the residence of Dr. Samuel C. Busey and elected the following officers: President, Dr. Samuel C. Busey; Vice-Presidents, Drs. J. Ford Thompson and W. W. Johnston; Secretary, Dr. G. Wythe Cook; Treasurer, Dr. H. L. E. Johnson. The following Committees were appointed by the President: Curriculum Committee, Drs. James Kerr, Samuel S. Adams, E. L. Tompkins, W. H. Wilmer and E. M. Parker; Executive Committee, Drs. H. L. E. Johnson, G. N. Acker and T. E. McArdle. The Constitution and By-Laws, as presented by the committee, consisting of Drs. H. L. E. Johnson, W. H. Wilmer and E. L. Tompkins, who were previously appointed to draft them, were read and adopted. Inasmuch as a number of applications for admission into the School had been already received, the Curriculum Committee was advised to hold a meeting as soon as possible and draw up a plan for conducting the course. The meeting then adjourned.

The Clinico-Pathological Society held its regular meeting on November 5, the President, Dr. H. B. Deale, in the chair. Dr. T. R. Stone read an interesting paper on "Circumcision."

The regular meeting of the Medical Society of the District of Columbia was held Wednesday evening, November 6, the President, Dr. Samuel C. Busey, in the chair. Dr. Isidor Bermann presented a New Instrument for the Relief of Deafness, which he had just invented. Dr. E. Oliver Belt read an interesting essay entitled "Consanguineous Marriage as a Factor in the Cause of Disease." The paper was well presented and elicited much discussion, those participating being Drs. W. K. Butler, D. K. Shute, S. O. Richey, F. B. Loring, I. Bermann, C. E. Hagner, C. H. A. Kleinschmidt, W. W. Johnston, J. W. Chappell, H. L. E. Johnson, S. S. Adams and W. C. Woodward. The meeting then adjourned.

The Commissioners are again considering the plan of building a hospital for contagious and infectious diseases. The Building Inspector is preparing a plan. It is intended for all contagious diseases except smallpox.

OFFICIAL LIST OF CHANGES IN THE STATIONS  
AND DUTIES OF MEDICAL OFFICERS.

## UNITED STATES ARMY.

*Week ending November 11, 1895.*

Major L. W. Crampton, Surgeon, granted leave of absence for three months, to take effect on or about December 1, 1895.

## UNITED STATES NAVY.

*For One Week ending November 9, 1895.*

Passed Assistant Surgeon L. W. Curtis ordered to duty at the Indian Head Proving Ground.

Passed Assistant Surgeon James Stoughton detached from the Puget Sound Naval Station and ordered to duty at the naval hospital, Yokohama, Japan.

Passed Assistant Surgeon C. F. Stokes detached from the naval hospital at Yokohama, ordered home and granted two months' leave.

Assistant Surgeon H. D. Wilson detached from duty at the Indian Head Proving Ground and ordered to duty at the naval hospital, Chelsea, Mass.

Assistant Surgeon C. D. Brownell ordered to duty at Puget Sound Naval Station, on completion of his examination for promotion.

## BOOK REVIEWS.

FULLER ON MALE SEXUAL DISORDERS. Disorders of the Sexual Organs in the Male. By Eugene Fuller, M. D., Instructor in Venereal and Genito-Urinary Diseases, New York Post-Graduate Medical School. In one very handsome octavo volume of 238 pages, with 25 engravings and 8 full-page plates. Cloth, \$2.00. Philadelphia: Lea Brothers & Co. 1895.

The author claims that the chief cause of sexual disturbances in the male is trouble in the sexual apparatus, especially inflammation of the seminal vesicles, nervous conditions being secondary. Neurotic and psychological derangements occupy a minor etiological significance, the latter exhibiting the smallest percentage of cases. The anatomy, physiology and pathology of the sexual organs are first fully considered, then the clinical side of the subject treated, the last chapter being devoted to illustrative cases. The author claims that the prostate has very little to do with sexual derangements, its influence being more manifest in connection with sexual drainage. Of inflammations of the seminal vesicles he found 14 to be due to gonorrhea; 7 to tubercles; and only 1 simple in character; syphilitic vesiculitis has not yet been demon-

strated. The author lays the greatest stress upon rectal examination for the confirmation of a diagnosis rendered suspicious by the symptoms and for ascertaining the extent of the trouble. For this the index finger must be trained. This draining and the method of "stripping" the vesicles in imitation of the normal ejaculation, upon which the author lays so much stress in the treatment, would seem to be not so easy in the one case and not so harmless as could be desired in the other. In chronic cases this stripping process might be advantageous by emptying the sacs, these convenient pus receptacles, but we doubt the propriety of this in acute cases. Still, whatever the result of this method, the author has furnished an interesting and valuable contribution to the somewhat obscure subject of sexual disorders.

**THE URINE IN HEALTH AND DISEASE, AND URINARY ANALYSIS, PHYSIOLOGICALLY AND PATHOLOGICALLY CONSIDERED.** By D. Campbell Black, M. D., L. R. C. S., Professor of Physiology, Anderson College Medical School. In one 12mo. volume of 256 pages, with 73 engravings. Cloth, \$2.75. Philadelphia : Lea Brothers & Co. 1895.

An excellent presentation of urology in its latest phase, concise, practical, clinical, well illustrated and printed. An interesting table at page 135 shows the results of the author's experiments to determine the relative value of the various albumen tests, which lead him to conclude that they stand in this order: Tanret's solution (open to certain objections), heat, nitric acid by Heller's method, acotropic solution. The author's results differ somewhat from those of other observers but he is a capable and experienced observer and merits confidence. Extreme delicacy is, however, not proportionate to utility and Jaccond and Roberts regard nitric acid and heat as superior to all other reagents. Roberts having shown that they enable us to detect albumen in a watery solution containing one part in 25,000 (Black says 1 in 263,158). We are glad to see Moore's test for sugar retained, page 161 ; some of the recent manuals have dropped it.

#### REPRINTS, ETC., RECEIVED.

*Studies on Lesions Produced by the Action of Certain Poisons on the Nerve-Cell.* By Henry J. Berkley, M. D. Reprint from the *Medical News*.

#### CURRENT EDITORIAL COMMENT.

##### THE GRADED SYSTEM.

*St. Louis Clinique.*

THE graded system of medical education is accomplishing great results, in more ways than even its devisers first conceived.

##### OBSERVATION IN MEDICINE.

*Medical Summary.*

IN order for the physician to become a successful healer, he must be a careful observer ; while holding fast to remedies that have faithfully served him in the past, his own prejudices, or those of others, must not be allowed to bar his trying the new remedies which may be brought to his notice from time to time.

##### RECIPROCITY.

*New England Medical Monthly.*

SINCE a number of States have passed laws making it compulsory for a graduate in medicine to pass an examination before a State board before he can practice, there has been a good deal of discussion in regard to one examination in any of the States holding good in every State that has a board whose examinations are of the same standard. Many correspondents in the different medical journals have ventilated their opinions and it seems to be the general consensus that one certificate given by any State board of examiners should hold good in another State, and be recognized by that board without another examination.

##### DISPENSARY ABUSE.

*Pittsburg Medical Review.*

THERE is one feature of the dispensary abuse question which seems to have escaped the attention of the complainants, namely, that persons able to pay, but who through misrepresentation obtain medical advice and medicine gratuitously at charitable institutions, are dishonest and would consequently prove unprofitable patients to those physicians who imagine themselves defrauded every time a patient passes through the door of a free dispensary. When it is remembered that dishonest persons are an integral part of every large community and that we have them with us always, just as certainly as we have the poor, it is not surprising that some obtain free service to which they are not entitled, but their number, at least in Pittsburg, is comparatively small.

# MARYLAND MEDICAL JOURNAL

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## ORIGINAL ARTICLES.

### TREATMENT OF INTESTINAL OBSTRUCTION.

READ BEFORE THE RICHMOND ACADEMY OF MEDICINE AND SURGERY, OCTOBER 22, 1895.

By *R. F. Williams, M. D.,*  
Richmond, Va.

*General Symptoms.*—In the chronic forms of intestinal obstruction, the first symptom noticed is some disturbance of defecation. Usually, this is constipation which has gradually increased, and which is often accompanied by tenesmus and pain. There may be diarrhea with bloody and mucous stools, or constipation alternating with diarrhea produced by irritation of old fecal matter or passive hyperemia. If there be a change of form in the feces, they will usually be flat and ribbon-like; the appearance of pea-like lumps in the stool, like the feces of a goat, is not diagnostic of obstruction, as the same occurs in other forms of constipation. There is a gradually increasing meteorism. Peristaltic movements of the gut may be seen through the abdominal wall, as this is thin from the general emaciation of the patient, and the gut wall is hypertrophied. Some authors have recommended this as a more or less efficient means of diagnosing the site of the obstruction; but, on account of the mobility of the gut and its frequent change of position, it is of doubtful value for this purpose.

Aortic pulsations may sometimes be felt transmitted through the distended gut.

Vomiting is a frequent symptom as the trouble advances, but it is rarely fecal.

Pain, colicky in character, is a usual symptom, although cases are recorded as proceeding without pain until complete occlusion. More or less anemia and emaciation are present and may be severe in such cases caused by carcinoma and tuberculosis. The chronic form may follow on the subsidence of an acute attack, but it is more common for an acute attack to supervene in the course of the chronic trouble.

The symptoms of acute intestinal obstruction are sudden pain in the abdomen, at first colicky, but becoming continuous, usually with exacerbations. The abdomen is tender and distended to a great or moderate degree according to the site of the obstruction; but there is no flatulence, and constipation is absolute except in intussusception, and in some instances, when fecal matter below the seat of obstruction may be voided.

Vomiting is a constant symptom, sometimes alternating with eructations. In the beginning of the trouble, the contents of the stomach are first vomited, then bile and later stercoaceous matter. This is not produced by a reverse peristalsis bringing the contents of the large gut into the stomach, but by putrid decomposition in the small gut, as is shown by the fact that in obstruction of the small gut stercoaceous vomiting occurs and is a more constant symptom in this

form than in obstruction of the large gut. The vomiting is caused by stretching of the peritoneum and by irritation of the stomach produced in the presence of abnormal matter which has entered when the pylorus is relaxed by pressure from within the gut.

There are rapidly developing symptoms of collapse. The pulse rapidly increases in frequency and becomes weak; the extremities cool and cyanotic; the eyes and cheeks sunken; the voice weak. The temperature is variable, though it usually falls. The tongue is dry and there is great thirst. The urine is scant and high colored and may even be suppressed when the obstruction is high, due, probably, to the constant vomiting and consequent small amount of fluid absorbed. Respiration may be interfered with by the distension and pain. Peristaltic movements may be seen through the abdominal walls; but this is not a constant symptom on account of paresis of gut wall, thick abdominal walls, etc.

The diagnosis of intestinal obstruction is always difficult and cannot be dogmatically given; as it must be made by differences in degree of symptoms for the most part; and perhaps, more certain in any other condition, is the judgment of the physician called in here.

*Diagnosis as to the site of the obstruction.*—Abdominal inspection and palpation give indications of the location by the detection of well-defined masses or active peristalsis in the distended coils. Rectal or vaginal examinations should always be made, as by these means the condition of the pelvic organs can be discovered and often, if the obstruction be low, it can be felt; while, if high, the fingers will find the empty coils depending into the pelvis. Rectal examination with the whole hand is not to be recommended. Obstruction of the small gut gives rise to greater anuria and there is usually an increased amount of indican in the urine, due to decomposition of albuminous matter, forming indol; while if the obstruction be in the large intestine, indican is not increased as the albuminous substances are not present there in such quantity.

In obstruction of the small gut, there

is greater vomiting, which becomes sternocostal early, and less tympanites, the distension being in the upper part of the abdomen if the duodenum or jejunum is the site of the obstruction, and in the central part, if the ileum be involved. Professor Monti of Vienna gives as a diagnostic point pain beginning about the umbilicus and radiating toward the stomach when the duodenum or jejunum is the site; while if the obstruction be lower down pain begins in the cecal region. He also considers the development of tympanites of diagnostic value if the case be seen early enough.

In obstruction of the large gut there is greater tympanites and vomiting comes on more slowly. Tenesmus and the passage of mucus and blood are commoner. For deciding the point of obstruction in the large intestine, rectal examination will give evidence of the involvement of the rectum and often of the sigmoid flexure. Inflation with a bellows or with bicarbonate of sodium and tartaric acid is a useful means. Knowing the capacity of the large gut to be about six quarts, distension of the gut by the injection of known quantities of water will frequently aid the diagnosis. For this purpose only a soft rubber tube should be used on account of the danger by a hard one. The patient should be anesthetized and have his buttocks raised. In both of these last mentioned means care must be used, as cases are on record where such methods have caused rupture. To further aid the diagnosis by this method, auscultation along the course of the large gut should be made, as the gurgling sound will give further evidence.

*Of the nature of the obstruction.*—Hernia should be excluded by a thorough examination of all possible parts for its occurrence. Strangulation is rare in the young. The history usually gives evidence of previous abdominal operations, peritonitis, or colic. The attack comes on suddenly, fecal vomiting occurs early; local tenderness is usually absent at first, but comes on later; constipation is absolute; fever may or may not be present. No tumor can be felt, as a rule.

Intussusception is commonly met with in children, occurring even in young infants. The onset is sudden. Pain, at first, is usually paroxysmal and tenderness is often absent, pressure often giving relief. Fecal vomiting is not a common symptom. Constipation is not the rule, but if the invagination occur in the small gut it may exist, when there will usually be more hemorrhage. Usually there are bloody stools, the amount of blood often reaching a severe degree of hemorrhage. There may even be diarrhea. Tenesmus is a frequent symptom, especially when the large gut is involved. If the affection be in the large gut, by rectal examination one may often touch the invaginated portion feeling like a softened, patulous cervix. The presence of a sausage-shaped tumor can usually be found by abdominal palpation.

Volvulus occurs oftenest in men of middle and advanced life. The diagnosis is always difficult, and often laparotomy is the only means of making it. The usual sites are the lower part of the ileum and most frequently the sigmoid flexure. The onset is sudden. Pain is at first intermittent, becoming constant later. Tympanites is marked, beginning frequently as a circumscribed area in the umbilical and epigastric regions and tending to the left side. Constipation is absolute and peritonitis appears early. The passage of a soft rubber tube and injection of water is especially useful for diagnosis in this form of obstruction, though some object to it, saying it increases the trouble.

Fecal impaction occurs most frequently in women and lunatics. There is always a history of previous constipation which, as a rule, gradually increases till the point of occlusion is reached; but the occlusion may be sudden. The commonest sites are the cecum and rectum. Constipation is usually absolute, but, when the impaction occurs in the rectum, the mass may be channelled, allowing the passage of feces from above and the patient for a long time be ignorant of any trouble. There is no blood in such actions. Eructation is a common and often distressing accompaniment of fecal impaction, but

vomiting does not occur till late and is very rarely stercoraceous. Pain and tympanites are also late symptoms. A tumor which pits on pressure can usually be felt by abdominal palpation and if the rectum be the site the trouble can be diagnosed by digital examination.

In impaction by gall stones there is usually a history of previous colics and fecal vomiting and pain occurs early. Jaundice is not often met with and a tumor is rarely found.

Constriction is diagnosed by a history of previous dysentery, syphilis, tuberculosis, typhoid, etc., in addition to the general symptoms of the chronic form of the trouble.

Obstruction due to paralysis of the gut wall from traumatism or other cause is usually accompanied by paralysis of other parts and is diagnosed by the history of such paralysis.

The course of the affection is variable, in acute cases ending in a few hours, or extending over a week or two. About six weeks is the usual period. In chronic cases, the duration depends upon the cause.

The prognosis is always grave, most cases ending fatally. In some cases, there is a possibility of spontaneous recovery, as when in intussusception the gangrenous portion is passed. One reason, probably, of the great fatality, is the long delayed surgical treatment.

Treatment for the relief of intestinal obstruction has been attempted in many ways, bullets in the 16th century, shot more recently; metallic mercury, purgatives, opiates, enemata, electricity, massage and laparotomy.

As the result of experience, it is now conceded that in most cases it is a waste of time to attempt alleviation by means of medical treatment, and that as soon as the diagnosis has been made, operative treatment should begin. Purgatives should not be used, but, in the early stages, the administration of opium greatly relieves pain by checking peristalsis. It also lessens the vomiting, but it must be borne in mind that it obscures the symptoms. Enemata should be tried early, except, perhaps, in volvulus; although in most cases little good may be expected. When these

have been used, and the water returns unchanged, the vomiting continuing, operation is indicated. Washing out the stomach is useful in relieving nausea and lessening the tension of the bowel. In some cases it has even proved curative.

For the relief of tympanites, puncture of the gut through the abdominal wall with a trocar and canula has been advised, but it is unsatisfactory, as, on account of the mobility of the gut, the portion below the obstruction may be punctured and there may result a septic peritonitis from failure of the gut walls to close perfectly. For this purpose, hot turpentine stapes may be tried, but are insufficient.

Mr. Jonathan Hutchinson, in the Report of the British Medical Association's meeting in 1893, advocates taxis for acute intestinal obstruction, claiming that in most cases his results were excellent, whereas he knew of only one case cured by laparotomy. This method is, having anesthetized the patient, to invert, and then to forcibly push and shake the intestines from side to side, large enemata being given while the patient is inverted. Then the patient is to be thoroughly shaken by four strong men, first in the inverted position, then in the erect. In some cases, he saw no immediate results, but, in an hour or two, the bowels moved and all went well.

In the acute affections the food should not be administered by the mouth, but only as nutrient enemata, otherwise it is immediately vomited and adds to the patient's discomfort.

Medical treatment is often efficacious and sufficient in two forms — intussusception and fecal impaction. Opium should be given in both cases, as it relieves the pain and vomiting, and, in case of intussusception, prevents further invagination. Enemata should be freely used. In intussusception, the patient should be put in the knee-chest position and a soft rubber tube inserted, water being slowly injected, the nurse pressing the buttocks together to prevent its escape. In fecal impaction, continuous enemata for half an hour at a time should be employed. These may be of soap water, oil, or turpentine and oil in the proportion of one ounce to the pint. Inflation with a bellows may be employed in cases of intussusception, instead of the injections of water, but care must be observed.

The stomach should be washed in both cases, as it relieves vomiting and tension, and prevents the absorption of noxious matter. It has also proved curative.

For cases caused by paralysis, electricity and massage may be of benefit.

If relief is not speedily accomplished by measures indicated, operation should be performed.

## A BULLET IN THE BRAIN; RECOVERY.

*By J. Zachary Taylor, M. D.,  
Deal's Island, Md.*

ON October 9, 1895, Lafayette Taws, aged 19 years, on an oyster vessel, was shot by an officer on one of the oyster police boats in Tangier Sound, and was brought to shore apparently dead. I was hastily summoned to the boat, and after seeing the condition of the patient, sent for my neighbor, Dr. Monmonier Rowe, to assist me. We carried the patient to the nearest house, and on examination, discovered the bullet embedded in the brain with one corner of the bullet in sight, and brain substance scattered over the boy's cap.

The bullet was seized by a pair of tooth forceps and extracted. The patient was then removed to his home to die, as life was about spent, but on reaching home, we gave him a hypodermic injection of nitro-glycerine  $\frac{1}{100}$  grain and sulphate of strychnia  $\frac{1}{50}$  grain, and the heart, which was barely perceptible, simply fluttering, began to beat and the pulse at the wrist showed signs of activity. After a half-hour, we repeated the dose and this had the happy effect of bringing the pulse up to that strength that encouraged us to etherize him

and remove the fragments of bone, etc. After etherizing him, we made the wound of the scalp larger so as to facilitate the work, and then removed the shattered bone and lifted the table of the skull that penetrated the substance of the brain. In all, we removed about as much bone as would make in circumference the size of a silver half-dollar, which left an oblong gap in the skull. When found, the boy was paralyzed on the right side, the wound being on the left, through the parietal bone, immediately over the arm and leg centers, the ball penetrating behind the fissure of Rolando, and the fractured skull in front of it.

While at work, portions of the disorganized brain ran out, and our calculations were that he lost an ounce of brains. We then thoroughly aseptized the wound by bichloride, dressed it and put him to bed to die, as we reasonably had cause to believe; in this we were mistaken, for in about fourteen hours after the operation, he had so far recovered consciousness as to respond when spoken to, but the arm and leg were completely paralyzed. He was not only paralyzed when we reached his side, but unconscious, and remained so until fourteen hours after we had removed the bullet and the crushed and broken skull. We then dressed the wound with gauze and bichloride daily, giving him hourly 12 grains of Epsom salts until the bowels were thoroughly evacuated, and the following antiphlogistic treatment every three hours :

R.—Calomel.	.	.	gr. $\frac{1}{4}$
Tinct. Aconit.	.	m. j	
Antimon. et Potass. Tar-			
trat.	.	.	gr. $\frac{1}{60}$
Morph. Sulph.	.	gr.	$\frac{1}{20}$
Pulv. Ipecac.	.	gr.	$\frac{1}{8}$

#### M.—Sig.

Milk diet was also ordered.

This treatment was kept up until the ninth day, when it was gradually discontinued. No fever or any sign of inflammation showed itself during the whole treatment. On the sixth day, he could lift his leg, and in two weeks could move it and stand on it. In three

weeks he could walk, although the gait was unsteady and wavering. At the end of the fourth week he can now use the upper arm, but the forearm and hand are yet useless, except in his sleep, when he can use the whole arm and fingers.

His recovery was, in our opinion, miraculous at best. He looks a little silly, but answers and asks questions with intelligence. The boy, when shot, was a half mile from the officers. The bullet, that weighed one ounce, ploughed the skull for at least an inch and then was deflected to an angle of about forty-five degrees, penetrating the brain and crushing in the tables of the skull, which cut through the coverings of the brain and let out the convolutions as aforesaid, and for five days the disorganized brain was oozing out of the wound. The bullet made one opening and the indented skull made another ragged opening into the brain, besides the fragments of skull bone which were driven into it.

Brown-Séquard spent a season to show that theory did not harmonize with fact. Quoting the anatomical statement that the parts behind and in front of the fissure of Rolando are the psychomotor centers of the arm and leg, he removed those parts from an animal, and the expected sequel failed. He showed cases where disease had destroyed those parts without producing paralysis. Then he noted paralysis of the face, arm or leg, and subsequently found undiseased the parts considered the motor centers.

In the face of all this, whom are we to believe? And what do we know about the brain and its diseases? In the case of this boy, we know that the so-called nerve centers of the arm and leg were wounded and destroyed, and that the boy suffered paralysis of both arm and leg, and yet he is fast regaining the use of both. We know one thing and that is if simply the medulla oblongata be punctured with a fine needle, death is instantaneous, and why Lafayette Taws did not die after such a frightful wound and loss of brain, my friend, Dr. Monmonier Rowe, and myself dare not venture an answer.

**SOCIETY REPORTS.****RICHMOND ACADEMY  
OF MEDICINE AND SURGERY.**

MEETING HELD OCTOBER 22, 1895.

Dr. Wm. S. Gordon, President, in the chair.

*Dr. R. F. Williams* read a paper on the DIAGNOSIS AND MEDICAL TREATMENT OF INTESTINAL OBSTRUCTION. (See page 91.)

*Dr. George Ben. Johnston* wishes to emphasize one point in the paper, that concerning fecal impactions. It is frequently overlooked, the symptoms being so obscure and misleading. The most common cause of fecal impaction is prolonged sojourn in bed whether due to disease or operation. This is debilitating, and in these cases there is also absence of irritating food. Usually there is no complaint of constipation, but of diarrhea. When continued, it is usually followed by tenesmus, pressure on the uterus in the female, on the bladder in the male. Later in the course of the obstruction, there is a feeling of something in the bowel and tenesmus becomes distressful. One is apt to administer astringents; but the most superficial examination reveals the presence of a mass which is found very low in the rectum, the finger coming into contact almost immediately. Purgatives not only are of no benefit, but do harm; enemata are unsatisfactory. Excavation with the finger is the only satisfactory method of relieving. If necessary, the patient may be anesthetized. One hand must press above the sigmoid flexure. Follow the operation by an enema of water and oil. Dr. Johnston says his routine when winding up a case that has been a long time in bed is to make an examination as described and he often finds impaction. He reported the following case seen in consultation with Dr. Warriner: Girl, aged 13, anemic, suffering from complete constipation for five or six days. Paroxysmal pains, tenesmus, mucous evacuations. Persistent nausea, stercoraceous vomiting, emaciation marked, pulse and respiration increased. She suffered from in-

somnia and restlessness; was extremely nervous and unable to take food. Upon superficial examination, both he and Dr. Warriner diagnosed intussusception. A careful examination revealed a sausage-like tumor across the umbilicus, confirming their diagnosis.

Laparotomy was determined upon, and while preparing for it the child dozed. It was noticed while she slept she would pluck a hair from her head, roll it into a little ball, put it in her mouth and swallow it. The mother said this was a habit. Doubtless she had done it for years. So convinced, said the doctor, that the obstruction was due to a bolus of hair that he did not operate. The tumor was situated in the transverse colon at this time. High injections of tepid water and Epsom salts were begun. The first came back unstained; a repetition was colored. It was determined to continue the injections at intervals of two or three hours. In the meantime, sustaining treatment was prescribed. The following day the staining was increased in amount. This convinced the doctors that the obstruction was not due to intussusception, but impaction, which had moved to the splenic flexure. The general condition was improved; nausea and vomiting had subsided; sleep was more peaceful and food was retained. That night there came away a bolus of hair six inches long, three inches in circumference and coated with hard fecal matter. Two years afterwards the child was treated for threatened obstruction. Copious injections of castor oil brought away the bolus.

*Dr. J. W. Henson* reported a case of obstruction in a girl of 14 years. She had typhoid and on the twenty-first day there was intestinal hemorrhage. He was afraid to give purgatives. For two weeks from the time of hemorrhage, fever continued. However, in a few days, there were frequent passages of masses as large as a fist. Oil was then administered and the character of the operations remained the same for three days. The oil was then stopped and improvement followed rapidly.

*Dr. J. A. Hodges* said he listened to

the paper with interest; that it covered well the whole ground, but there was one remedy to which no reference was made. Belladonna pushed till its physiological action is manifest is indicated in any kind of an obstruction. In one case, operation was about to be performed when the belladonna, which had been administered previously, produced a movement. Enemata, said the doctor, are never properly administered, except by the physician himself. They should always be used before operation is decided upon. The best is of kerosene oil, of which he has used as much as a pint at a time. It is a lubricant and irritant. During the injections the buttocks were held up for half an hour, if need be, and it is wonderful to find how far the oil penetrates. If there is no tympanites, taxis or massage may be employed to hasten its action. In the case of a brakeman who had no diarrhea, there occurred, while attending to his duties, a sudden pain like that of hernia; but on examination nothing much was found. An enema brought nothing, when a coal oil enema produced a small movement. On opening the abdomen a commencing hernia was found. The strangulation was removed and the patient recovered. Soon after obstruction recurred. This time the oil gave relief. The doctor has never observed any bad effect from the oil.

*Dr. W. W. Parker* reported two cases of impaction, both in aged women, both requiring two days for their removal. One began in October and was not removed till the February following. In making post-mortems the doctor had often found scybalae where they were never suspected.

*Dr. Henson* reported that in the case of a girl of seven years, he had used for five days purgatives and enemata without result. The contents of the abdomen could be felt, but no lumps were revealed. It was decided to remove her to the hospital for operation. Before doing so, belladonna was administered and the operation deferred and for two days the use of the drug was continued, producing movements which became regular. Enemata were also continued.

*The President:* Experiments show that the carbonate of sodium dissolves scybalae. The hint is worth remembering. Alkaline remedies are solvents and there is no reason why they should not be given for that action by the mouth. They act on the center and sides of the mass at the same time.

*Dr. J. S. Wellford* finds enemata of strong solutions of salt very efficacious. He follows their administration by salts, senna and manna. He thinks we err in giving the solid extracts, as they are of small bulk.

*Dr. Edwards* thinks ox-gall injections efficacious. It acts better than all other remedies combined, a natural purgative and solvent. He uses a bladder for each injection.

MARK W. PEYSER, M. D.,  
Secretary and Reporter.

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#### SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

ABSTRACT OF THE PROCEEDINGS OF THE EIGHTH  
ANNUAL MEETING, HELD IN WASHINGTON,  
D. C., NOVEMBER 12, 13 AND 14, 1895.

##### FIRST DAY, MORNING SESSION.

The Association met in the banquet hall of the Hotel Shoreham at 10 A. M., and was called to order by the President, Dr. L. McLane Tiffany of Baltimore.

*Dr. S. C. Busey* of Washington delivered an "Address of Welcome" on behalf of the medical profession of the District of Columbia. In his closing remarks, Dr. Busey said: "I solicit your aid and coöperation in our effort to secure the protection of our people from the horde of impostors and charlatans, which you have driven from your borders by the enactment and enforcement of medical practice laws, and which has made the District of Columbia a common rendezvous where the most atrocious methods of the charlatan and mercenary impositions are openly and flagrantly committed to the wrong, injury and robbery of its citizens. You represent the most influential and intelligent class of suffragists for whose aid on the hustings and at the polls we plead. To state the deplorable condition of this

District fully and broadly, there are five medical schools and several medical societies chartered by acts of Congress, or under the general incorporation law authorized and empowered to license persons to practice the art and science of medicine, without any uniform, and by some, without any standard of qualification, beyond the ability and willingness of the applicant to pay the required fees, or give promissory notes for such payment; and under the provisions of the general incorporation law, any dozen of persons can obtain a charter upon payment of the fee for recording the same, authorizing them as a body corporate to confer the degree of M. D., at their pleasure and will. Such is the status of this Federal territory, which is under the exclusive jurisdiction of the highest tribunal of legislation in the land, made up of the Representatives and Senators from forty-nine States and territories, which have enacted medical practice laws for the protection and welfare of their citizens. Take these facts home with you and re-echo them throughout the length and breadth of the land, that such criminal neglect, not less disgraceful and scandalous than the slums of vice, may not continue to afflict the citizens of the Federal territory."

*President Tiffany* responded to the Address of Welcome for the Association.

After some announcements had been made by Dr. Joseph Taber Johnson of Washington, Chairman of the Committee of Arrangements, the reading of papers was taken up.

Dr. Bedford Brown of Alexandria, Va., read a paper entitled "Personal Experience in the Treatment of Stab Wounds of the Intestines and Peritoneum." At the outset, the author stated that about one hundred and thirty cases of stab wounds of the peritoneum and intestines had come under his care during his entire professional experience in both private and military practice. In less than one-third of the cases the intestines were wounded. It is a little remarkable, said the author, that there should be such a disproportion in the number of intestinal wounds in these cases; in other words, it is a singular

fact that in a large majority of abdominal wounds the intestines escape injury even when such wounds are extensive. Transverse and longitudinal stab wounds of the intestines were then considered at length.

Dr. Brown regards the saber wound as one of the most dangerous in its immediate and remote results. If the edge and point of the saber are sharp the wound inflicted is large and deep. The weapon cutting through the intestines and mesentery, usually passing through the abdomen, severs large blood vessels and causes frightful hemorrhage, which is speedily fatal. He had only seen three saber wounds of the abdomen and they ended fatally in a brief time. The stiletto is a dangerous instrument, as it almost invariably enters an intestine or other organ. It does not kill by hemorrhage usually, but makes an opening in the intestine sufficiently large to permit the escape of a small quantity of fecal matter, causing septic inflammation. It is one of the most difficult of all intestinal wounds to detect. The diagnosis of intestinal wounds was then dwelt upon, reference being made to Senn's hydrogen gas test to detect wounds of the intestine. While he considered it a useful test, in remote sections of the country far from large cities and towns it is not practicable because of the impossibility of procuring the apparatus and generating the gas. In all abdominal stab wounds, the author's rule has been, after cleansing the hands and thoroughly disinfecting them, to insert the index finger and explore the intestine to ascertain if there is an opening. In certain cases a wound may exist in the intestine, but it may be so small as to escape detection. But if the intestine is wounded, whether we can insert the finger or not, there is always more or less extravasation of fecal matter and gases, and if the finger comes in contact with this matter it is certain to retain for a length of time the peculiar odor of human feces. This will afford positive evidence of an intestinal wound. In treating simple wounds of the peritoneum, the author's rule has been to close them with silver wire sutures after thor-

ough disinfection. Formerly he closed these wounds without regard to anti-septic measures, except that the wound was washed with hot water and soap. On the battlefield and in field hospitals, wounds were washed with any water that was convenient, and were not washed at all when water could not be obtained. Previous to the introduction of antiseptic treatment in dressing wounds, but little attention was paid to the condition of instruments, sutures, sponges or dressings except the practice of ordinary cleanliness, and the percentage of cases of healing by first intention of simple wounds of the peritoneum was large. In dressing simple wounds of the peritoneum scrupulous attention should be paid to the laws of cleanliness. In treating wounds of the intestines two vital procedures are necessary. One is a complete and thorough closure of the intestinal wound; the other is to cleanse the peritoneal cavity of all fecal matter, blood and gases escaping from the intestine. Dr. Brown then described a simple method of reducing a protruded intestine in stab wounds. He takes two long, slender, curved needles, threaded each with a silken cord 10 or 12 inches long. One of these needles is passed midway through the margin of the wound, the other needle is passed through the opposite margin and then each cord is tied in a separate loop. These cords are drawn in opposite directions by two assistants, upwards and outwards, firmly and tightly. By this means the wound is made to expand or gape widely, and at the same time the walls of the abdomen for a large area around the wound are very considerably elevated above the intestines, while the patient reclines in the dorsal position, and a considerable vacuum is in this way created and the intestines will glide back without force or manipulation to fill this newly created vacuum.

Dr. Richard Douglas of Nashville said that in peritoneal wounds we always have a mixed infection, which is more serious than an infection from the colon bacillus. Peritonitis, whether local, adhesive, general or septic, should be considered of germicidal origin. In

closing the abdominal wound, he thinks it is proper to always approximate the peritoneum, as by so doing we lessen the danger of hernia.

Dr. C. A. L. Reed of Cincinnati expressed himself as being apprehensive about mere exploration with the finger to detect stab wounds of the intestines. However erudite the tactile sense of the surgeon may be, at times it would prove misleading, and therefore in certain cases it was exceedingly important to enlarge the original incision or wound, and that part of the viscera lying immediately beneath it should be brought out and carefully inspected. He believes with Dr. Douglas that the peritoneal margins should be carefully approximated.

Dr. James Evans of Florence, S. C., related an instance where nine men had received chest wounds by the bayonet during the war, the bayonets having been previously stuck in the ground, and yet all of the men recovered. He attributes their recovery to the form of wound made by the bayonet. In another case, a man had been shot within half an inch of the navel. He had no rise of temperature, yet when he saw the patient the omentum had extruded to the size of his two hands. He applied a double ligature, then put a piece of adhesive plaster over the surface, and the man recovered. He had frequently seen gunshot wounds of the abdomen during the war in which there was extravasation of fecal matter through the wound, but unaccompanied by shock.

Dr. A. Vander Veer of Albany had always made it a practice to first inquire carefully as to the kind of weapon by which the wound is made. He had seen several of the wounds inflicted by bayonets during the war, but does not remember of having seen the intestines or stomach penetrated by them. There should be no delay in treating stab wounds. The surgeon should act promptly and not wait for symptoms to present themselves. Just as a case of perforative appendicitis will terminate fatally in a short time, so will stab wounds of the intestinal tract, unless timely interference is resorted to.

*Dr. Hugh T. Nelson* of Charlottesville, Va., said the necessity of enlarging the abdominal wound, under all circumstances, was an imperative one. Four years ago he saw a case in which the small bowel was wounded by a knife and the patient refused operation for twenty-four hours, believing that this viscus was not cut. Symptoms became alarming and the patient finally consented to have an operation performed. Dr. Nelson opened the abdomen by a long incision, finding it impossible to remove from the peritoneal cavity the extruded contents of the bowel, owing to the fact that an adhesive inflammation had taken place and had agglutinated them to the bowel so firmly that he could not wash them away. He attempted to resect the peritoneum into the pelvic cavity where the fecal matter had burrowed, but could not do so. Peritonitis became general and the patient died. The sooner the abdominal incision is enlarged in stab wounds the better.

*Dr. George Ross* of Richmond asked whether there was any way of distinguishing between the symptoms of nervous shock and shock due to hemorrhage.

*Dr. Brown* replied that one of the most unerring symptoms was rapid reduction of temperature, but there was no symptom that would enable the practitioner to distinguish accurately between the different forms of shock except the gravity of the condition.

*Dr. W. E. B. Davis* of Birmingham desired to speak of the point in reference to injuries of the gall bladder. The essayist referred to the fact that injury to this viscus would produce a septic peritonitis. An injury that would produce peritonitis would result in death very soon if there is a large escape of bile into the peritoneal cavity, but Dr. Davis does not believe it is a septic peritonitis. He believes that in the majority of cases the shock following abdominal injuries is due to hemorrhage and that hemorrhage plays an important role in the production of symptoms in those injuries. It was the hemorrhage from these wounds that frequently caused death.

*Dr. John D. S. Davis* of Birmingham

expressed himself in regard to the diagnosis of intestinal wounds, as having very little confidence either in Senn's hydrogen gas test, or the flushing method spoken of by the essayist. He had seen perforative wounds of the abdominal viscera where it was impossible from their character and location to flush the abdominal cavity through the opening sufficiently to thoroughly clean it. In addition to the three forms of shock mentioned by the essayist, there should be added the shock of sepsis.

*Dr. Brown*, in closing, agreed with Dr. W. E. B. Davis that all cases of violent or dangerous shock were due to hemorrhage. In regard to approximating the peritoneum, he had always left it untouched in closing simple wounds in the abdominal wall and had found it good practice.

*Dr. A. Vander Veer* of Albany, N. Y., read a "Report of Seven Cases of Abdominal Surgery in which the Murphy Button was Applied." The author stated that the seven cases he desired to present had a bearing upon the use of the Murphy button which is now receiving attention both in this country and abroad, and as a method of intestinal anastomosis is being placed thoroughly on its merits. It is difficult to understand some of the unfavorable reports made by English and German surgeons when we contrast the very successful results indicated by so many of our American operators in the practical application of this mechanical device. Perhaps there is no part of surgery that within the past quarter of century has presented so much in theory, and in which there has been so much disappointment when practical use has been made of the suggestions, as in the field of abdominal work with all of its complications. In other words, how much we have changed from time to time our methods of treatment of many complications and yet, withal, there have come certain reliable advances that have met all requirements for which they were indicated, leaving permanently in our possession the comforting thought that a grand progress in the sum total has been made; that we can treat all

manner of pathological conditions, traumas, malformations, etc., of the intestinal tract and abdominal cavity with less embarrassment than perhaps in any other part of the body, and yet there are very few portions of the human system upon which we operate where more rapid thought and best judgment are to be employed than in abdominal work. The first case was one in which gastrointestinal anastomosis was made for carcinoma of the pyloric end of the stomach by means of the medium-sized Murphy button, between the upper end of the jejunum and greater curvature of the stomach. Patient was comfortable after the operation, but died from exhaustion on the third day. Case 2 was carcinoma of the sigmoid flexure, removal and end-to-end anastomosis. Operation consisted of removing a mass in connection with the sigmoid flexure, three inches in length, and an anastomosis of the large intestine by means of the button. Cause of constriction was found to be carcinoma. Patient died from exhaustion the eleventh day. But was much exhausted and emaciated previous to the operation. Case 3. Removal of gall stones from the gall bladder, using the long drainage tube button. Recovery. Case 4. Removal of eight inches of the small intestine with papillomatous ovarian cyst. End-to-end anastomosis by the button. Perfect recovery. Case 5. Anastomosis of the gall bladder with small intestine. Recovery. Case 6. Operation revealed a tumor the size of a cocoanut, in the immediate vicinity of umbilicus, a portion the size of a silver dollar implicating the umbilicus and in a gangrenous condition. On making an incision there was found a strangulated hernia and many old and firm adhesions. Peritoneum intensely congested; very dark in color. Loop of small intestines included in tumor and gangrenous for space of ten inches. Vessels in mesentery secured and this portion of the intestine excised. Murphy button used for end-to-end anastomosis. Button passed thirteen days after operation, followed by a large movement of the bowels. Uninterrupted recovery. Case 7. A

diagnosis of biliary calculi was made in this case. Dr. Vander Veer made the usual incision for exploration of the gall bladder, found it containing about two ounces of bile, and through the walls and down into the cystic duct could be felt a number of small calculi. There were some adhesions. He made use of the long drainage tube button to the fundus of the bladder and closed the wound after a careful examination for any possible cancerous mass, which was found not to be the case, then placed the patient in bed. He regarded the use of the button in this instance as a saving of time, leaving the patient in good condition for removal of the gall stones later. Several days after he had made the exploratory incision the attending physician removed five irregularly-shaped calculi, which Dr. Vander Veer exhibited. At this time the patient began to show marked symptoms of cerebral anemia, with delirium, which continued, patient finally passing into a comatose state and died; temperature just before death reaching  $105\frac{1}{2}^{\circ}$ . Dr. Vander Veer said that although the cases he had reported were not many, yet they covered a field in which the Murphy button might be made use of so readily and easily and the result so satisfactory that he considered them worthy of attention as having a bearing upon statistics. He believes he had given a just criticism of the accumulation of facts, so that we could reach and determine definitely as to the value and usefulness of this contrivance. The Murphy button will not answer for every lesion about the intestinal tract, but surely has its sphere of usefulness, being clean, easily handled, and saves the patient from a much longer operation, when time alone is the great desideratum, which cannot be secured by some of the other methods.

*Dr. H. H. Grant* of Louisville followed with a paper entitled "Intestinal Resection and Anastomosis." He said there had always been a division of judgment upon the question of immediate suture in acute obstruction or injury, requiring resection of the intestine, which even the improvements in technique and means of aid in operative

work have not adjusted. The members were all familiar with the Murphy button, and doubtless many had employed it. What it is intended to do, it does well; but too often it does what is not intended, and disaster and death result. There is abundant evidence that it becomes a foreign body; that it occasions spreading necrosis, which involves the peritoneal coat; that recontraction takes place after lateral anastomosis; that fatal results are frequently directly attributable to its use, besides other less important objections. Lateral anastomosis is now beyond all question the most acceptable method of resection of the continuity of the bowel, if we exclude the button. It is best to accomplish by direct suture, and direct suture is of difficult execution except in very skilled hands. In order to facilitate this suture, Dr. Grant presented a device for clamping opposing surfaces of the bowel, cutting off fenestra between them, and retaining them so opposed until the suture can be completed. He then demonstrated the *modus operandi* of his device. He had experimentally used the clamp sixteen times with fourteen consecutive recoveries, but had had but one opportunity to use it in practice. On May 25, he operated on Mrs. E., aged 53 years, who had a fecal fistula at the right femoral opening, the result of a strangulated hernia, operated on eight months ago. An incision was made just above Poupart's ligament near the fistulous opening. The fingers easily liberated the intestine, which presented an opening occupying half its lateral surface and as large as a quarter of a dollar. The mesentery was greatly thickened; the distal segment of the bowel was reduced in size, the proximal dilated at the site of the fistula. About four inches of the intestine was resected; the blades of the clamp were applied opposite the mesenteric borders of each segment, and the anastomosis made as above described. After suturing, the communication between the opposing surfaces was found ample. The cut ends were then invaginated and the anastomosis returned; the abdominal wall closed with silkworm gut sutures; the

site of the fistula curetted and filled with iodoform gauze and the patient put back to bed in forty-two minutes. There was very little shock. At the present time the patient is well. The advantages of this method over the other aids, except the button, are manifest. Not only does it do away with the foreign body, but cuts an opening three or four inches long at the fenestra. It is fully as easily accomplished, and takes less time. It is no more difficult to use than is the button, but the operation cannot be so quickly completed, as the invagination of the ends is not necessary after the end-to-end approximation by the button. The clamp merely makes direct suture easy to any ordinarily skilled hand.

Dr. C. A. L. Reed said experience would establish the fact that the Murphy button ought not to be used in approximation of the large intestine, for the reason that the intestinal contents were not sufficiently liquid to pass through the small opening in the button. In the small intestine it is different. There we have liquid contents that will pass through the opening in the button and the approximation is satisfactorily accomplished. Dr. Reed reported a case of resection of the sigmoid for malignant disease (which terminated fatally) in substantiation of the above remarks, the anastomosis being made by means of the Murphy button. He commended the device presented by Dr. Grant, and although he preferred the end-to-end procedure, he would try the device in the next case in which he performed lateral anastomosis. Cholecystenterostomy by means of the Murphy button was one of the easiest, neatest and altogether most satisfactory operations known to surgery.

Dr. Joseph M. Mathews of Louisville said he had taken occasion more than once to call attention to the difficulty that attends diagnostinating tumor of any kind in the sigmoid flexure. Time and again he had been mistaken, as he believed others had, in supposing that he had malignant tumor of the sigmoid when he had not, and supposing, on the other hand, that he did not have when

he really did. A few years ago a patient was brought to him from an adjoining State, and from evidence outside of palpation he believed that the man had malignant trouble of the sigmoid flexure. A few days thereafter he was taken to Chicago, was examined by a very eminent surgeon, who positively stated that there was no tumor of any kind in the flexure, and advised the patient to go home and go to work. In less than a week the man was dead. Autopsy revealed carcinoma of the sigmoid flexure. His reasons for opposing resection of the sigmoid and making anastomosis by the Murphy button were in substance the same as Dr. Reed's. Cancer in the sigmoid flexure was not only usually attended by systemic infection, but there is an involvement of other organs and tissues of the body. He would therefore ask, could a man live any longer after a surgeon had removed the tumor than he would if it was left untouched? Granting that there is total obstruction, would it not be better to perform colotomy and let the man live out his allotted days with cancer in a more pleasant way than he would if an operation were done? In lieu of this, it had occurred to him that the plan suggested by Dr. Bacon of Chicago of anastomosing the colon to the rectum, leaving the growth there, would be a more favorable operation than extirpation of the carcinoma.

Dr. A. M. Cartledge of Louisville said in doing a cholecystostomy there was not much time saved by using the Murphy button, and it was not as useful as the ordinary method of suturing. He thought this was well illustrated in one of the cases reported by Dr. Vander Veer in which there was a passage of stones after the operation, and where it was necessary on account of the extremely feeble condition of his patient. In cases with numerous small calculi extending into the cystic and common ducts, he had made a comparatively large incision in the gall bladder and sutured it to the peritoneum, where the stones could not be removed, and they would then pass for days externally through the drainage tube. The orifice

in the button is too small to permit the stones to pass, whereas they would escape through a drain and come out. He expressed himself in favor of Dr. Grant's device, and considered it an excellent one for lateral anastomosis.

Dr. W. E. B. Davis believes the Murphy button can be used to advantage in intestinal work where it is necessary to do operations quickly; otherwise the method of stitching similar to that practiced by Abbe is better, is more certain, and accidents are not so likely to follow it as by the use of a mechanical appliance which is non-absorbable. Cholecystenterostomy by the button should be resorted to only in those cases where it is impossible to remove the obstruction in the common duct. The old method, as pointed out by Dr. Cartledge, is decidedly better in the other class of operations.

Dr. Vander Veer, in closing, was satisfied that the end-to-end anastomosis with the button in the large intestine was not likely to be a satisfactory procedure, inasmuch as the caliber of the button was such as not to permit of the passage of hardened feces through it, while in the small intestine the feces would easily pass through the orifice in the button. He believed Dr. Grant had presented an appliance that would be of value to the profession. The fact that new devices were being presented from time to time before medical gatherings for intestinal anastomosis was ample evidence that we had not yet reached an ideal method. The Murphy button is an excellent device in the performance of cholecystenterostomy and other operations.

Dr. Grant believes that any surgeon of ordinary skill with his device, after having the two surfaces of the bowel directly opposed, can suture them without soiling the peritoneum or letting them slip away.

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SEPTICEMIA.—The latest treatment for general septicemia (*Journal of Practical Medicine*) is hypodermic injections of creasote, mixed with equal parts of camphorated oil, and 20 minimis of the solution are injected three times a day.

## MARYLAND

## Medical Journal.

PUBLISHED WEEKLY.

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BALTIMORE, NOVEMBER 23, 1895.

THE recent political upheaval in Baltimore and Maryland will naturally affect many positions, which are the gifts of *Health of the City and State.* With these appointments the medical profession, as a rule, has little to do. Among other things, there is some reason to anticipate a change in the city health department and also in the State Board of Health.

Whatever the new Governor may do in reference to this last named body, he can hardly fail to make an improvement. The work of the present State Board of Health is hardly representative of what should be done in Maryland and cannot be compared with the boards of health in many smaller and younger States. Sanitary science, preventive medicine and hygiene in general have made such advances and everything connected with them has been so revolutionized since the era of modern bacteriology, that a health board

which does not make itself acquainted with the most recent knowledge of this subject stands little chance of scientific recognition, does not keep up with the times and is hardly a credit to its State or to the profession of that State. The State Board of Health of Maryland could do good work if it were reorganized on a scientific and not a political basis.

The present Board in Maryland has probably done as well as it could with the amount of money it had at command and with the men composing it, but if the medical profession would honestly and conscientiously take a non-partisan and unbiased interest in these appointments, and would present their views as a body to the new Governor it is hardly likely that these wishes would be altogether ignored. The great trouble has always been with the medical profession in questions political, that they were not united in ideas and opinions and too often attempted political methods without understanding them.

The position of health officer for the city of Baltimore will be eagerly sought for by men in no way equipped for the place. The position is a responsible and important one and the profession here should be united in putting forward a man who will do his work well. There are probably few of the better physicians of Baltimore who do not wish to see the present incumbent retained in office. He has had the experience of many years; he has been through epidemics of diseases, he has done his duty as well as he could, under the circumstances, and much better than many others in his place would have done; he has been universally courteous and polite to the public and to every member of the profession even when unreasonable demands were made on him, and he has been handicapped by having a corps of men who were not altogether of his own choosing.

The profession has united on this man and the Mayor will hardly turn a deaf ear to the wishes of the physicians. An ideal board at the present day should have a scientific and educated chemist, a good bacteriologist and a body of intelligent inspectors, by preference young men of the medical profession.

The new Mayor seems inclined to retain in office men who have done their duty and men supported by public-spirited citizens. Modern sanitarians with executive ability are not numerous in any city, and even the best men

fall short of their best efforts when their assistants are selected by politicians who do not understand the needs of the office.

It is the universal wish of the medical profession of Baltimore that the present health officer of that city should be retained in office and knowing these facts the Mayor will undoubtedly follow out his ideas of Civil Service Reform by retaining a good man and thus win the esteem and confidence of the medical profession.

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AN exchange announces that the little town of Phenix, Arizona, which many persons now hear of for

*An Anti-Noise League.* the first time, has recently organized an Anti-Noise League. If noise disturbs places of that size there is no wonder that the inhabitants of large cities complain against the clamor and the crying of hucksters, the clanging of bells and the rattling of vehicles of all kinds. Much of this noise is necessary, but some of it can be avoided and especially the ringing of bells and the blowing of whistles. Baltimore has a law forbidding steam railroad engines from blowing within the city limits, but the steamboats and the factories keep it up at certain hours at a deafening rate. In the morning, at lunch time and in the evening, the large factories blow for what seems to be a very long time ; and then the clocks, not all being alike ; one whistle succeeds another, until for ten or fifteen minutes, at least four times in the day, these sounds are repeated. An ingenious mathematician has calculated the amount of steam which represents work that is wasted in this blowing. Another great nuisance is the almost continual clanging of the rapid transit cars. Some of this is undoubtedly necessary, but in many cases the motormen remind one of a small child with a new toy, so ready are they to ring. Here there is no waste of material or forces as in the blowing of steam whistles, but the wear and tear on the nerve force and patience of the hapless city dweller is hard to calculate. The invalid on a thoroughfare suffers much from this unnecessary noise. All this wears on the brain and produces that brain tire which is so characteristic of the hard worker in a city who never takes a day off and works like a galley slave. If it could be decided when these noises were necessary and when not legislation or public

opinion would soon regulate matters, but car companies maintain that the ringing of bells is necessary to warn persons against the rapid approach of a car. If the motormen would use discretion and judgment, and ring when the track is not clear and not ring when there is no danger, then this ringing would soon grow less. The constant rush for wealth, or even for a living, the noise of the city and the dodging of the rapid cars and stealthy bicycles will deepen what the Germans call the "anxious wrinkle" in the American's brow and which gives a chronic expression of anxiety that months of peaceful repose cannot repair.

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THE meeting at Belair is over and those who took part in the proceedings of the Faculty and who were pres-

*The Belair Meeting.* ent feel highly gratified at the work done. The papers read were in most cases good, the discussions at times spirited and the time was fully occupied.

Too much praise cannot be given to the Harford County Medical Society and the local profession of Belair for the kind attention and the entertainment which they bestowed on the visiting guests. Such meetings rarely fail to do good and help to bring closer together the profession of the State and make acquaintances which are lasting.

Each year since these semi-annual meetings have been revived the profession has taken greater interest in them and even in such a busy season as the present physicians have found time to spend at least one of the two days at these meetings.

The value of these semi-annual gatherings is again shown in the annual meeting and in the increasing membership and prosperity of the Faculty. In this union there is strength ; and unanimity of opinion and action in a powerful society like this one cannot help favoring legislation for the good of the profession and therefore for the good of the public.

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THE annual hospital collections will be made today and tomorrow, and while physicians are not expected to contribute, their donations will be very acceptable. They can, however, assist by reminding their wealthy and benevolent patients how they may give in a way that will do much good.

**MEDICAL ITEMS.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending November 16, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		14
Phthisis Pulmonalis.....		14
Measles.....	129	
Whooping Cough.....	5	3
Pseudo-membranous Croup and Diphtheria. } Mumps.....	19	8
Scarlet fever.....	14	
Varioloid.....		
Varicella.....		
Typhoid fever.....	6	2

The Virginia Hospital at Richmond is to be enlarged.

Dr. Bernard Wolf now owns and edits the *Southern Medical Record* of Atlanta, Ga.

The Illinois Medical College, of Chicago, has been incorporated and opened its doors September 14.

Dr. Geo. J. Engelmann has removed from his former location in St. Louis to 336 Beacon Street, Boston.

In South Dakota and New York trained nurses are sent after insane patients to be taken to an asylum.

Dr. Daniel Lewis of New York has been appointed President of the State Board of Health of New York.

Dr. Trudeau's sanitarium in the Adirondacks will receive \$5000 from the late Samuel Inslee of New York City.

Billroth, Skoda and Rokitansky are to have monuments in the Court of Honor of the University of Vienna.

Dr. Lauder Brunton has at last received his well-merited promotion, and is now Physician to St. Bartholomew's Hospital, London.

A correspondent of the Académie de Médecine of Paris has written a letter proposing to the Académie to ask for the creation of a tax upon corsets.

It is said that in Paris over one hundred thousand persons ride the bicycle and almost all physicians use it in their daily work and prescribe its use.

The Board of Governors of the Nurses' Association of Baltimore is giving a course of lectures to which all graduate nurses are invited to be present.

Pills in Great Britain to the number of between six and seven million are estimated to be daily consumed; that is, on a basis of three grains to a pill, half a ton by weight.

Dr. Thomas Keith, the distinguished British gynecologist, died at London in the first week of October, at the age of seventy years. He was a most successful abdominal surgeon.

The death is announced of Dr. T. J. Bland of Martinsburg, West Virginia, and formerly of Maryland. Dr. Bland was graduated from the University in 1887. He leaves a wife and one son.

Dr. Charles E. Simon of Baltimore has just finished the manuscript of a very exhaustive work entitled "Clinical Diagnosis by Means of Microscopical and Chemical Methods." Lea Brothers of Philadelphia will publish the work, which will be very fully illustrated with original drawings.

For the first time in ten years the response to the appeals in behalf of the hospitals in London has been successful beyond expectations, the sum realized for the hospitals through the Sunday fund being £70,000 (\$350,000). In previous years it has ranged at about £40,000 (200,000).

The publishers of the *Index Medicus* have almost enough money guaranteed to continue the work. For some unexplained reason the subscriptions of the Clinical Society of Maryland and the Medical and Chirurgical Faculty of Maryland do not appear in the list and if any medical societies have subscribed in Baltimore their names have not appeared.

The Medical Society of Washington County held its quarterly meeting at Hagerstown last week and elected Dr. J. W. Humrichouse of Hagerstown, President; Dr. V. M. Reichard of Fair Play and Dr. W. C. Wheeler of Boonsboro, Vice-Presidents; Dr. C. D. Baker of Rohrersville and Dr. Henry U. Onderdonk of the College of St. James, Secretaries; Dr. C. R. Scheller of Hagerstown, Treasurer. Papers were read by Drs. H. S. Herman and J. W. Humrichouse of Hagerstown and discussed by the members. Dr. J. McP. Scott, the retiring President, read the annual address.

## WASHINGTON NOTES.

The regular meeting of the Medical Society of the District of Columbia was held on Wednesday night, November 13, the President, Dr. S. C. Busey, in the chair. Dr. G. M. Kober, who was recently appointed special sanitary inspector in relation to typhoid fever, read a paper entitled "Impure Milk in Relation to Infantile Mortality." It was discussed by Drs. George M. Sternberg, Surgeon-General United States Army, D. E. Salmon, Chief of the Bureau of Animal Industry, Department of Agriculture, S. S. Adams and others.

The Southern Surgical and Gynecological Society, which was holding its annual convention here, was invited to be present. This Society had a very successful convention here for three days, November 12, 13 and 14 respectively. The papers were all good and were read and discussed by representative men. They also received much attention while in this city, having had in their honor a reception and collation by the Washington Obstetrical and Gynecological Society at the Arlington Hotel, on Tuesday evening, and on the following evening Dr. Joseph Taber Johnson gave a beautiful reception and supper.

The Inauguration of President Whitman of the Columbian University took place at Convention Hall on Friday night. All the Faculties of the College, all the students and many others were present, filling the vast hall to overflowing. The speakers were the Rev. Dr. Strong of Rochester, Dr. Patton of Princeton and President Whitman.

The programme for the Washington Obstetrical and Gynecological Society for Friday was a paper by Dr. F. S. Nash, entitled "A Plea for the New Woman and the Bicycle," but the Society adjourned to attend the inauguration of President Whitman.

The smallpox hospital, which has been the talk here for a long time, is expected to be finished very soon and it is thought that an isolation hospital will be built near it.

Dr. James Kerr has just returned from a visit to Montreal.

## PUBLIC SERVICE.

## UNITED STATES ARMY.

*Week ending November 18, 1895.*

The leave of absence granted Major Joseph K. Corson, Surgeon, is extended twenty days on Surgeon's certificate of disability.

To be Assistant Surgeons with the rank of First Lieutenants, November 6, 1895, Thomas Jellis Kirkpatrick, Jr., John Hamilton Stone, Irving Wallace Rand.

Lieutenant Colonel Joseph R. Gibson, Deputy Surgeon General, retired from active service, November 15, 1895, on account of disability incident to the service.

Thomas Jellis Kirkpatrick, Jr., and John Hamilton Stone appointed Assistant Surgeons, with the rank of First Lieutenant, to rank as such from November 6, 1895, and ordered to report to the President of the Army Medical School for instruction.

The leave of absence granted Captain Eugene L. Swift, Assistant Surgeon, is extended one month and he is authorized to go beyond the sea.

## UNITED STATES NAVY.

*For One Week ending November 16, 1895.*

November 11, 1895, Surgeon T. Owens detached from Naval Station, Port Royal, S. C., and granted three months' leave.

November 12, 1895, Surgeon J. R. Waggener detached from the "Independence" and ordered to the Mare Island, Cal., Navy Yard.

Surgeon George P. Bradley detached from the Mare Island, Cal., Navy Yard and ordered to the "Indiana."

Passed Assistant Surgeon George Rothganger detached from Naval Hospital treatment and ordered to the "Independence."

Assistant Surgeon H. LaMotte detached from the "Constellation" November 16, and ordered to the Naval Hospital, Chelsea, Mass., November 18, 1895.

November 13, 1895, Surgeon J. E. Gardner ordered to Port Royal, S. C., Naval Station.

## BOOK REVIEWS.

A MANUAL OF OBSTETRICS. By A. F. A. King, A. M., M. D. Sixth edition. Lea Brothers & Co. Philadelphia: 1895. 12mo. Pp. 533.

This popular Manual has been much improved by the latest revision. The author has aimed no higher than to present an outline of obstetric art, but he has done more; he has furnished the student with a very good treatise on the subject, with numerous illustrations. Seventy-one new illustrations have been added but the author disclaims any attempt at originality either in illustration or text. That his effort to present a condensed text-book has succeeded is quite evident both from an examination of the work and from the fact that it has reached a sixth edition in the short space of thirteen years.

**CURRENT EDITORIAL COMMENT.****GOOD JOURNALS REPAY.***The Journal.*

THE country physician can use his money to much better advantage than in buying the larger treatises, by subscribing for as many good journals as he can read and every three to five years such works on special subjects as he needs. There are few medical books that are not "old and gray" in five years in these days of medical progress.

**MEDICINE A TRADE.***Physician and Surgeon.*

A PHYSICIAN employed by the New York worker's union makes the statement that his visits net him about one cent each. An enterprising merchant in Belgium issues coupons to his customers, who make purchases of twenty cents or upward, which entitle them to the services of a physician. A tea merchant in the English metropolis supplies medical service to the purchaser of every pound of tea. Is medicine a profession or a trade? or is it merely a "premium" designed to enliven trade?

**REST AND RECREATION.***Columbus Medical Journal.*

THERE is perhaps no other class of men whose duties are so exacting, so confining, of such a routine and ever-straining character as those of the physician. He is burdened with care from morning till night. He goes to his bed with the "sorrows of others" weighing on his mind only to arise burdened with their affliction in the morning. He is not only responsible for the life and health of his patients, but often for the prosperity of their families. His reputation is constantly at stake, and to mar his reputation is to steal his capital, and to interfere with his health and vigor of mind is to undermine his reputation. We believe that all these circumstances combined make the duty of the physician more exacting, burden him with greater responsibility and force him to harder study and closer confinement than any other man in the professional arena. This being the case, it is highly important that he should have some physical relaxation, and that his nervous system should have a rest, and the nerve cells be given a temporary freedom from their constant strain.

**PUBLISHERS' DEPARTMENT.**

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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**NOTES.**

LISTERINE is the ideal antiseptic.  
\*

IN the first stage of senile pneumonia, an emetic is indicated.  
\*

FOR the relief of all scrofulous manifestations, prescribe Iodia.  
\*

FREQUENT gargling with guaiac is said to prevent or abort tonsillitis.  
\*

BORAX used in the water in which one bathes will check perspiration.  
\*

BEAR in mind the therapeutic value of solutions of eserine in corneal abscess.  
\*

CHRONIC catarrh of the mucous membrane is often relieved by alkaline diuretics.  
\*

IN hay fever, try one-hundredth-grain doses of strychnia arsenite every two hours.  
\*

EDEMA of pharynx is said to be the first symptom in acute poisoning by the iodides.  
\*

BELLADONNA locally applied will be found very useful in cases of localized neuritis.  
\*

MENTHOL, ethereal solution, ten to fifty per cent., applied by camel's hair brush, aborts boils, carbuncles and inflammatory gatherings and will cure itching eruptions.  
\*

OPIUM acts more powerfully in the presence of acids than in that of alkalies; consequently in rheumatic diathesis, where the alkaline plan of treatment is adopted, it may be given without fear.

# MARYLAND MEDICAL JOURNAL

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VOL. XXXIV.—No. 7. BALTIMORE, NOVEMBER 30, 1895. WHOLE NO. 766

## ORIGINAL ARTICLES.

### TEARS OF THE CERVIX UTERI; THEIR SIGNIFICANCE AND REPAIR.

READ AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY  
OF MARYLAND, AT BELAIR, NOVEMBER 19 AND 20, 1895.

By *J. M. Hundley, M. D.*,

Associate Professor Diseases of Women and Children, University of Maryland, Baltimore.

I MIGHT feel that I should offer an apology for bringing before you such a commonplace subject as tears of the cervix uteri, but for the fact that our experience at the University of Maryland Hospital warrants us in the belief that many of the symptoms ascribed to such lesions are frequently due to other causes and that, therefore, the repair of such lesions is often unnecessarily done.

Few first labors are completed without more or less laceration of the cervix, whether the labor be a normal one or not. Where dilatation of the cervix is accomplished by the bag of waters laceration is less likely to occur than when accomplished by the head of the child. A fruitful source of laceration is where instruments have to be used within the uterus, when the cervix is not fully dilated.

I am convinced that lacerations occur much more frequently than we are aware of, and where the puerperium runs an afebrile course they frequently heal without surgical interference. What part laceration of the cervix plays in the prevention of the normal involution of the uterus I do not think is at all settled. It is true every lesion occurring in the birth canal at the time of labor adds to the chances of septic infection; if infection does not occur I believe the uterus

will return to the normal, in spite of the laceration, in the great majority of instances, as I have over and again seen demonstrated. I, therefore, feel that infection is oftener the cause of the subinvolved uterus following labor than the simple laceration of the cervix. Where we have no infection the cervix may be torn even to the vaginal junction and the process of involution will go on, leaving a normally healthy uterus.

The significance of tears of the cervix depends very much upon the individual bias of the medical adviser. One man may refer every symptom with which some worn-out and debilitated woman may be suffering to an insignificant tear of the cervix. At Dr. Howard's clinic in the University of Maryland Hospital we have just such cases applying for treatment. It is true cases that enter the hospital through the dispensary are poor, ill-fed and with the worst of surroundings, but they come with the history of womb disease, and that they have been told they had a tear in the neck of the womb and it must be operated on—that all of their bad feelings, headache, sick stomach, nervousness, etc., are all caused by the tear. We look upon such cases differently and have long since come to the conclusion that there are but few tears of the cer-

vix, within themselves, that give rise to sufficient ill-health as to need operation.

The extent of the tear is no indication that it should be operated on ; many tears reaching nearly to the vaginal junction require no treatment, local or surgical. Consequently we do not assume because a woman comes with worn-out nerves, brought about by wakeful nights with a cross and perhaps overfed baby, or the many petty annoyances of every-day life, or what not, and with this neurasthenic condition is frequently associated backache, fainting spells, headaches, nausea, pains at the back of the neck, bearing-down pains, irregular menstruation and leucorrhea, that some lesion of the cervix is the cause, though upon examination we find quite an extensive tear.

And just here I should like to relate briefly the history of a case recently under my care which aptly illustrates the stand taken as to simple tears of the cervix. About twelve months ago a highly cultured and nervous woman gave birth to her first child ; the labor was somewhat difficult and forceps were used. Her puerperium was uneventful and without fever. She was up and around in about twelve days, with an abundant milk supply for the baby. As the baby grew and fattened the mother became more and more emaciated, her sleep was frequently interrupted during the night. She easily tired ; had palpitation of the heart at times, some bearing-down pain, when on her feet for any length of time. This condition was at its height, when the baby was about six months old, and at which time the mother paid a visit to her former home in a neighboring city; while there she was advised to consult a specialist as it was certain she had some uterine trouble ; she did so, and was told that she had a tear of the cervix, for which she was treated every other day preparatory to the needed operation, which was to have been done in a few weeks. For some reason she became dissatisfied and came back to Baltimore and consulted me. I made an examination and found she had a bilateral tear of the cervix

very nearly to the vaginal junction, the lips of the cervix were thin and soft and lay in good apposition, there was no hypertrophy, the uterus was not only thoroughly involuted but had undergone lactation atrophy. This condition of the uterus known as lactation atrophy is not a pathological one. Those of you who have examined many nursing women have now and then found this condition of the uterus. No doubt I have demonstrated it repeatedly in my dispensary work at the University of Maryland. It is considered by W. Thorn, writing in the *Centralblatt für Gynäcologie*, a pure reflex trophoneurosis entirely dependent upon lactation, and disappearing upon its cessation.

To return to the case in point. The woman was told that while she had a tear it was a trivial affair and needed no operation ; that she must begin to feed her baby and nurse him less, and that she must sleep more and look after her general health in the way of taking tonics, etc. She is today perfectly well and weighing nearly as much as she has formerly. No leucorrhea or other evidence of uterine disease exists. This case is similar to others we every now and then encounter and I can but believe that this operation devised by Dr. T. Addis Emmet, while a most valuable one in well selected cases, has done more harm than it has been of benefit. In fact, I have been creditably informed that Dr. Emmet shares the same belief.

While believing that there are but few cases of laceration of the cervix needing operation, I am, however, conscious of a class that urgently demand operation, and I cannot do better than give you the history of a case operated on at the University of Maryland Hospital about eighteen months ago. It is a typical case and one that I have been able to keep track of up to the present time, and is therefore of more value for that reason. The history is as follows : Mrs. H. D. C., white, 29 years of age, mother of three children, no miscarriages that could be verified, had enjoyed fair health up to birth of her last child, which was two and a half years ago ; nothing unusual was apparent at

this labor either to her attendant or to herself.

She recuperated slowly, however, and continued to have a profuse leucorrhæal discharge, when she was not bleeding, from the time her baby was four weeks old to the time she consulted me. The frequent and irregular hemorrhages she had had during that time had rendered her an invalid, spending most of her time upon the bed; if she attempted to move about to any extent it was almost sure to bring on bleeding. She had in this two and a half years by great care, the use of ergot and alum douches, been free from bleeding for six weeks at a time. After that interval she would be taken with a profuse bleeding, and it was thought at the time by her medical attendant to be a miscarriage. She had several such occurrences in the two and a half years. Besides the leucorrhæa and irregular bleeding, she had back-ache, bearing-down and dragging pains; she was greatly emaciated and extremely nervous.

It was clearly evident from such a history that she had some uterine disorder. A vaginal examination revealed a large subinvolved, retroverted uterus, with a bilateral tear extending to the vaginal junction—the lips of the cervix were greatly hypertrophied and everted. An operation was advised and done after two weeks' preparatory treatment. I do not know that it is absolutely necessary to resort to this preparatory treatment in every case, but this patient was so depleted from the loss of blood, and the cervix was so greatly hypertrophied, we thought best to pursue the course above indicated. The treatment consisted in opening numerous little cysts and depleting the cervix by local abstractions of blood, douches of hot water, and the use of boglyceride tampons. The uterus was also curetted and its cavity found filled with vegetations. After this curettage she had no further bleeding. The cervix became softer under this treatment and was operated on in about fourteen days.

The operation did not consist of simply taking away with scissors a thin layer

of tissue, but the tissue was freely exercised with a knife to get rid of all scar tissue and with the view of getting more rapid and perfect involution. We have found that where there has been full excision of tissue, of course within certain limits, we are more apt to get good involution than where the edges of the tear are simply pared off. The sutures were of silkworm gut and placed in the usual manner. In fourteen days they were removed, the cervix presenting a normal appearance, with good union in line of incision. The uterus, in that short time, had greatly decreased in size. We were in this case, as we are in every case, extremely careful to leave a good-sized cervical canal and external os to insure free drainage. Nothing is more hazardous and defeats the end sought more surely than tightly sewing up cervices.

Before the patient left the hospital a pessary was introduced to overcome the retroversion. It was some months before she regained her flesh and accustomed strength, but when she consulted me at my office three months after the operation she told me she menstruated only the first month after leaving the hospital and not since, and she feared she was pregnant. Upon examination I found the uterus in good position and reaching nearly to the top of the pubes; there was unmistakable thinning in the lower uterine segment. This peculiar thinning was first demonstrated by Hegar, and is commonly known as Hegar's sign of pregnancy, and in our experience is one of the most valuable signs of early pregnancy. I gave the opinion that she was pregnant and in due time she gave birth to a living child and was well when last heard from. I have not examined her since the birth of the child.

We not only believe that the repair of simple and insignificant lesions of the cervix are needlessly done, but we further believe that the operation, when done on those cases calling for it, is often improperly performed. In the past year we have had to open up three cervices that had been sewed up so tightly as to give rise to constant pelvic pain and

weight, which symptoms were greatly exaggerated at each menstrual period. One case, only operated on five weeks ago, had an external os to one side of the cervix and so small as not to allow the introduction of the smallest-sized probe. The uterus measured four inches and was large and hyperplastic. It is needless to say that with such a uterus, with a cavity four inches in depth and the subject of a long-standing endometritis, it was one of the worst of all surgical procedures. One would condemn very strongly such a procedure elsewhere in the body. When we have a diseased cavity constantly pouring out a pathological secretion, it should be the aim of good surgeons always to provide ample and easy drainage.

To recapitulate, we believe :—

1. That but a small percentage of tears of the cervix uteri demand repairing.
2. That the extent of the tear, within

certain limits, is no indication that it should be repaired.

3. That when hypertrophy of the lips with eversion exists, the operation is demanded ; provided the appendages are fairly free from disease. If this condition of hypertrophy is associated with subinvolution of the uterus of not too long standing, the results of an operation will be all that could be desired. If sufficient time has elapsed for this subinvolution to have taken on fibrous tissue hyperplasia, the results will be less satisfactory.

We cannot urge too strongly the importance of maintaining an ample cervical canal and external os for the purpose of free drainage, as there is always associated in the operable cases more or less endometritis, and such endometritis means a constant outpouring of mucus that needs being gotten rid of quickly and easily.

## TREATMENT OF ADVANCING CORNEAL LESIONS IN GONORRHEAL OPHTHALMIA.

READ AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, AT BELAIR, NOVEMBER 19 AND 20, 1895.

*By Hiram Woods, M. D.,*

Associate Professor Eye and Ear Diseases, University of Maryland, Baltimore.

DANGER in purulent conjunctivitis lies in involvement of the cornea. This danger, it is recognized, is in direct proportion to the extent of inflammation in the ocular membrane and is greater the earlier the cornea is affected. There are three sources from which corneal mischief may come.

1. Interference with circulation. Inflammatory exudates into the mucous and subjacent tissue mechanically interfere with the vascular loops about the limbus from which the transparent membrane obtains nourishment.

2. Direct infection.

3. Pressure on the cornea from pus and swollen lids.

Of these, the latter can readily be prevented. Recognizing the importance of and enforcing cleanliness, even if it becomes necessary to do canthotomy, or

even Critchett's splitting operation, free outlet for the pus can be obtained. The others are avoided often with great difficulty. The greater the conjunctival chemosis around the cornea, the more probability is there of organisms lodging under the circum-corneal swelling and infecting the corneal periphery. Thus, resisting powers are depressed and opportunities for infection increased by the same cause. With the central cornea clear, advancing crescentic ulceration is sometimes found beneath the conjunctival ring which arises around the periphery.

It is not within the province of this paper to discuss at length means to prevent this infiltration. Briefly, they are, in the onset, leeches and cold. These failing, scarification is by some thought useful. Nitrate of silver stands preëmi-

ment as a remedy after pus formation. It also combats the circulatory disturbances calculated to weaken the cornea. Soelberg - Wells (*Text-book*) says:—“ Its effect, as originally explained by von Graefe, is to contract the blood vessels and to accelerate the circulation, which is retarded, the conjunctiva being at the same time vascular and congested and its vessels dilated. Moreover, the serous infiltration is greatly relieved by the copious serous effusion which follows the cauterization.” To this must now be added the germicidal effect of silver solutions. The strength of the solution generally used is 2 per cent. (gr. x to  $\frac{3}{4}$ ).

Dr. Norris (*Norris and Oliver's Text-book*) is doubtless right when he says that more depends upon the thoroughness of the application than the strength of the solution. It should be applied with a brush or pencil of absorbent cotton to every part of the conjunctiva, special attention being paid to the retro-tarsal folds. When infection is very virulent, as indicated by profuse secretion, great swelling of the conjunctiva and lids, neither condition yielding much to the 2 per cent. silver solution, stronger solutions or the mitigated stick are admissible. After such cauterization, says Wells, the eye “ becomes hot and painful and this is accompanied by increased lachrymation and a mucous discharge. The eschars which are formed upon the palpebral conjunctiva are shed in from thirty to sixty minutes in the form of little yellowish-white, rolled-up flakes. Inflammatory symptoms soon subside, the conjunctiva becomes less turgid, the lachrymation and purulent discharge diminish and the stage of remission sets in, during which the epithelium is regenerated. When this has taken place, the conjunctiva becomes more red and swollen, the discharge increases in quantity and the inflammatory symptoms in severity. It is of consequence to endeavor by renewed cauterization to cut short this third period at the outset, before it has regained its original intensity. We shall thus be able by degrees to extend the duration

of the stages of remission and to diminish the intensity of the inflammatory stage. Generally, it will suffice to apply the crayon once in twenty-four hours.”

Regarding the management of corneal complications, authors refer to chapters upon corneal diseases, without, for the most part, discussing them from the standpoint of a suppurating conjunctiva. Atropia, iodoform, paracentesis through the floor of an ulcer, when perforation is imminent, and in later text-books cauterization of the corneal ulceration with carbolic acid, strong silver solutions, or the actual cautery. These are the most important remedies suggested. Regarding the cautery, Noyes (*Text-book*) thinks its results not so uniformly good as in primary ulcer. Juler (*Text-book*) advocates it in secondary ulceration, while De Schweinitz (*Text-book*) mentions it as a substitute for paracentesis.

In 1891, Prof. Chisolm, when absent from the city, left in my charge a medical student with a commencing corneal purulent infiltration, secondary to gonorrhreal ophthalmia. Its progress was arrested temporarily by the actual cautery, only to start again in the cauterized area after three days, and, in spite of a second cauterization, to destroy the entire cornea. The 2 per cent. silver solution was continued after each cauterization. I have always had misgivings concerning the adequacy of the treatment instituted. The lids were swollen, conjunctiva chemotic, secretion profuse; and this in spite of several days' use of the 2 per cent. silver solution. Secondary infection started from the point of cauterization, after the eschar had been thrown off. I determined that if again called upon to treat a progressive corneal infiltration occurring in an eye afflicted with gonorrhreal ophthalmia to combine cauterization of the conjunctiva with strong silver solution, as described in the above quotation from Soelberg-Wells, with cauterization of the corneal ulcer by the same agent. Until this fall, I have not had an opportunity to test the merits of this treatment. The two following cases seem

to show that it is not without usefulness :—

CASE I. Mrs. M., 65 years of age, contracted double gonorrhreal ophthalmia, apparently from using an infected towel in a friend's house. This, at least, was the nearest I could get to the source of infection. She came to the Presbyterian Eye and Ear Hospital in September, ten days after the appearance of purulence. In each eye blenorhea was profuse. Lid infiltration and conjunctival chemosis were insignificant. The left cornea was perforated along its upper fifth, with large iritic protrusion. The whole cornea was gray. The right eye presented a typical crescentic corneal ulcer, about half way through the cornea, and involving in extent  $\frac{1}{5}$  to  $\frac{1}{4}$  of the upper circumference. There was no vascularity about the edges of the ulceration and the floor was of a dirty gray color ; in a word, it was a foul, progressive ulcer. Microscopic examination of the pus in the Pathological Laboratory of the University of Maryland showed gonococci. There had been no proper treatment from the beginning, so a day was given to the 2 per cent. silver solution, and bichloride cleaning. At the expiration of 24 hours, purulence was unabated, while the ulcer involved a little more of the circumference and had advanced into the cornea. Under cocaine, I cauterized the conjunctival sac above and below with a thirty grain solution of nitrate of silver. With a fine probe, armed with absorbent cotton, the ulcer was touched with the same solution. Purulence ceased at once. The next day it reappeared, when the conjunctiva was cauterized a second time. After a second twenty-four hours, although the ulcer had not advanced, it was not clean and I cauterized it, including also the conjunctiva. There was no further return of inflammatory symptoms. The ulcer cleaned, and recovery was uninterrupted.

CASE II. George B., 25, colored, admitted to the Presbyterian Eye and Ear Hospital first week in October. Double gonorrhreal ophthalmia and gonorrhea. The right conjunctiva was infiltrated, hard, and chemotic around the cornea.

Upon lifting the edges, haziness along the upper corneal border was observed. The left eye was less severely affected. Microscopic examination of the pus showed gonococci. The left eye recovered uneventfully under the 2 per cent. silver solution. The right showed little benefit after two days devoted to this solution, cleanliness, cold and scarification. The ulcer, which I carefully watched, remained foul, but did not seem to advance during this time. On the third day the cornea at the extremities and along the inner margin of the ulcer became gray. Dr. Bird, Resident Physician, now cauterized it and the conjunctiva with the silver solution, in the same manner as described in Case I. It had to be repeated in 24 hours, after which recovery was uneventful.

Just as most of the *curable* cases of blenorhea yield to the 2 per cent. silver solution, so most of the *manageable* corneal complications are amenable to milder methods than cauterization. At the other extreme stand cases hopeless from the beginning. A small area of infection rapidly destroys the weakened cornea. Efforts to stop its progress—successful usually in primary infection—not only fail but seem harmful. Probably defective vascular supply is the trouble. Between these two there is a third class to which the above cases belong : Steadily advancing, destructive corneal lesion, which, if occurring without blenorhea, would be promptly checked by the cautery. The presence of purulence demands something more than *corneal* disinfection.

This something must include : First, a means of stopping corneal infiltration, not too violent for the uninfiltrated, but doubtless poorly nourished, corneal tissues to withstand.

Second, a method of promptly reducing pus formation to a minimum in order to prevent reinfection of the cleaned corneal area. These requirements exclude the actual cautery on the one hand and mild silver solution on the other. The cases here recorded seem to indicate silver cauterization of mucosa and corneal lesion as useful.

**SOCIETY REPORTS.****SOUTHERN SURGICAL AND  
GYNECOLOGICAL ASSOCIATION.**

ABSTRACT OF THE PROCEEDINGS OF THE EIGHTH  
ANNUAL MEETING, HELD IN WASHINGTON,  
D. C., NOVEMBER 12, 13 AND 14, 1895.

## FIRST DAY, MORNING SESSION.

*Dr. J. McFadden Gaston* of Atlanta, Ga., read a paper on "Surgical Interference in Rectal Disorders." After outlining the anatomy of the rectum, the author said it is a mooted point in regard to the practicability of eradicating rectal troubles of syphilitic origin by medication, and with the present light on the subject it seems justifiable to resort to such a surgical measure as the condition indicates, while constitutional treatment is being carried out in the case. There are instances of supposed development of specific disease in the form of stricture of the rectum, after the lapse of many years subsequent to any syphilitic contamination; some authors claim their ability to diagnosticate specific stricture even without a previous history of primary syphilis. Strictures of the rectum from fibrinous depositions in its walls call for division or excision of the structures involved. When carcinomatous induration of the rectal tissues is detected early, there is encouragement to undertake an operation, but after the breaking down of the neoplasm with infiltration of surrounding structures, no benefit is derived from excision of the parts involved. The rectum affords material for surgical work of the most important character, and it should not be relegated to those professing to deal with so-called orificial surgery. Dr. Gaston is fully impressed with the conviction that many cases find their way into the hands of quacks, which ought to be treated by members of the regular medical profession, and preferably by those who have made a special study of rectal diseases and are prepared to treat properly all the surgical disorders of the rectum. Reference was then made to a paper by Dr. Gerster, read before the American Surgical As-

sociation, upon the surgery of the rectum in 1893. The burning and urgent appeal to the surgeon today is for a definite settlement of the issue as to active interference in cases of pronounced cancer of the rectum. Shall we content ourselves with the more palliative measure of inguinal colotomy and leave the diseased structures untouched, as urged by Dr. Mathews in his paper before the American Medical Association, or shall we endeavor to remove all the tissues involved by extirpation, as recommended by Dr. Gerster? The full statistics of results in the hands of skilled operators ought to be collected and a fair analysis made before a final adjudication of the question can be reached. The materials for such a comparison should be obtained from cancer hospitals in this and other countries, as well as from general hospitals receiving and treating this class of patients, and being grouped together a fair inference may be drawn as to the feasibility of active interference in any case of carcinoma of the rectum.

*Dr. J. M. Mathews* said the essayist incidentally alluded to fissure of the rectum giving rise to reflexes. He was glad he mentioned this simply to emphasize the point, that to have reflexes from the rectum we must have a pathological condition. The so-called orificial surgeons had run wild with reflexes from the normal rectum, and as a consequence many respectable citizens in his own city had lost healthy rectums. In regard to stricture of the rectum, his observation has been that benign rectal stricture is very seldom met with. There were cases, however, mentioned by authorities, but Dr. Mathews had failed to find them. If he does find it, it is simply an annular constriction of the mucous membrane which is easily dissipated. It does not require excision. When the surgeon introduces his finger into the rectum and finds stricture there, it betokens one of three serious diseases — syphilis, tuberculosis or cancer — and the patient should not be turned aside with a jesting remark that he has a rectal stricture. It is a serious thing. He maintains that sixty per cent. of the cases of stricture of the rectum arise

from syphilis, or are the result of it. He had asked his professional friends to investigate this matter and make known their investigations. The responses he had received were nearly all in the affirmative. He regards stricture of the rectum as more frequent than either cancer or tubercle. With reference to excision of the rectum for a cancer that has blocked the rectum to the sigmoid flexure, in nearly every instance we have systemic infection. This being the case, can the man be cured by surgical interference? He wished, like Dr. Gaston, we could successfully remove the rectum for cancer, but he doubts it.

*Dr. H. M. Nash* of Norfolk, Va., had seen a number of cases of ulcer of the rectum cured by dilatation of the sphincters and topical applications. He uses the Sims speculum, placing the patient in the exaggerated Sims' position, which gives the operator all the room he wants for manipulation in the rectum.

*Dr. Gaston*, in closing, congratulated Dr. Mathews on his attitude of masterly inactivity in a great many cases of carcinoma of the rectum.

#### FIRST DAY, AFTERNOON SESSION.

*Dr. George H. Noble* of Atlanta, Ga., read a paper entitled "One Hundred and Sixty-Six Cases of Cancer of the Pregnant Uterus Occurring Since 1886." The author's attention was directed to this subject by four cases that came under his observation and his success in dealing with them had encouraged him to look more carefully into the treatment and as a result he had collected a hundred and sixty-six cases of cancer of the pregnant uterus, which had occurred since 1886, the time of the Bar thesis. Dr. Noble then confined himself mainly to the statistics of the treatment and results, referring to Bar, Cohnstein and others for information concerning the age, the period of recurrence, the period of abortions, etc. There were twelve partial amputations of the cervix in the seven months of pregnancy, averaging five and a half months; 96.6 per cent. of the mothers recovered from the operations, while 8.3 per cent. died; 66.6

per cent. went to full term, one child dying subsequently, and 41.6 per cent. aborted. Two mothers had subsequent operations performed for the removal of cancer, but there was recurrence in both cases. Another conceived a second time, and died thirteen days after confinement of peritonitis. Of the three cases of intra-vaginal amputation of the cervix, two recovered from the operation, giving a mortality of 33.3 per cent.; the children the same. One mother died of peritonitis, one died suddenly six weeks after confinement, and the third had two subsequent operations for the removal of the malignancy, making an ultimate mortality of 66.6 per cent. and possibly 100 per cent. The intra-vaginal amputations give a combined mortality from operations, of mothers 19.3 per cent., of infants 40 per cent. Sixteen supravaginal hysterectomies were done prior to the seventh month, with a mortality of 6.2 per cent.; six had recurrences of the disease, three had no return, and seven were not observed. There was therefore an ultimate mortality of 66.6 per cent. In the nine cases in which the records are complete, thirteen cases were lost, a mortality of 82.5 per cent. Of the remaining three, one went to full term, and the other two were not mentioned. One case aborted thirty-five days after conception, aborted again in forty-days, conceived a third time, was delivered normally, and was well five years afterwards. There were twenty-three vaginal hysterectomies. In two cases the results were not recorded, leaving twenty-one cases, all successful. There were seven cases of vaginal hysterectomy in the puerperal period, from fourteen to twenty days after abortion or delivery, all recovered. The total number of abdominal hysterectomies was 16; 12 of these were Freund's operation, one after Mackenrodt's method, and the remainder not described. Of 11 cases, 7 died from the operation, making a death rate of 43.7 per cent. One case had enchondroma of the pelvis; another had return of the cancer in one year, and a third had a return in a few months, and died seven days after an operation for

ileus due to cancer of the intestines. These three are the only ones with complete records; therefore it is impossible to give an estimate of the ultimate recoveries. The products of conception were all lost. Cesarean section was done forty-three times as follows: Conservative (or Sänger) 26; Porro 9; Freund's 8 times. Of the 26 conservative operations, 16 died and 7 recovered; in two the results are not recorded, and one was dead before the operation was performed, mortality in 23 cases being 43.7 per cent. The number of recoveries in the Cesarean-Porro operations were four, deaths five, mortality of 55.5 per cent. In eight Cesarean sections by the Freund method, there were three recoveries and five deaths, giving a mortality of 62.5 per cent. A short summary shows: 1. That vaginal hysterectomy should be safe in the early months of pregnancy and the puerperal state, when there is a reasonable hope for the mother. 2. That abdominal hysterectomy should be done when the uterus is too large to be rapidly and safely removed through the vagina. 3. That at or near the end of pregnancy Cesarean section should be resorted to when the child's interest is to be considered. 4. That Cesarean section with Freund's operation is permissible when the disease is confined to the uterus and the child is viable. 5. That in doubtful cases, cutting of the cervix and rapid delivery may be judicious when the incision can be made in non-ulcerated or non-infiltrated tissue. 6. That as there are four chances to one against the life of the fetus, and as an equal number of mothers may be ultimately cured in the early stages of the disease, the safety of the fetus should not be allowed to hazard the life of the mother; and that, upon the other hand, the futile efforts directed to the interest of the mother, when her case is hopeless, should not jeopardize the safety of the fetus in the latter months of pregnancy.

Dr. Howard A. Kelly of Baltimore said that cancer of the pregnant uterus is rare. He had seen but three cases. If the cancer is seen in the early stage, when it presents itself as a mere nodule on the cervix, not apparently extending

into the broad ligaments and pregnancy is approaching, it would be safe to let pregnancy go on to full term and labor to take place naturally. Per contra, if the cancer has advanced to such an extent that there is a possibility of involvement of the broad ligaments, the surgeon could not operate too soon, because under the conditions of pregnancy the growth of cancer of the cervix is much more rapid than it is ordinarily.

Dr. Vander Veer of Albany stated that four years ago he operated on a case, doing a vaginal hysterectomy. Pregnancy had advanced about four months. He felt happy about the case for two and a half years, at the end of which time cancerous nodules presented themselves at the site of the cicatrix. Pregnancy had advanced to full term. The patient lived for a period of eight months. The pelvis was filled with a cancerous deposit. Dr. Vander Veer reported another case of cancer of the pregnant uterus, and while the patient recovered from the removal of the uterus, she subsequently died from recurrence of the disease.

Dr. E. S. Lewis of New Orleans contributed a paper entitled, "Hysterectomy for Fibroids." The author said that hysterectomy for fibroids, now a justifiable and recognized operation for the preservation of health, the prolongation and the saving of life through important operative procedures, minimizing the element of risk, had reached its present enviable position by the substitution of direct ligation of the uterine arteries, for the unsatisfactory methods heretofore employed to secure immunity from hemorrhage, these measures often failing to prevent bleeding and not infrequently there was exposure to infection through the region of the cervix. Complete hysterectomy, whether by the vaginal route in fibroids of moderate size, through the abdomen in certain cases, or by the combined abdominal-vaginal method in other instances, heralded a brighter era for the future of hysterectomy. That exceptions might occur with regard to individual cases, rendering the complete operation inadmissible, he was prepared to admit. The author then reported eight cases in which the complete

operation was practiced. Case 1. Patient aged 53. Tumor the size of a seven months' pregnancy. Operation performed March 11, 1894. Incision from pubes to two inches above umbilicus. Omentum detached from anterior surface of tumor to which it was adherent; a portion of omentum ligatured and cut off on account of free oozing. The subperitoneal fibroid attached to the fundus was lifted out and upper portion of ligaments ligated and divided. The bladder was then detached and vaginal roof opened in front and behind. The lateral vaginal connections and lower portion of broad ligaments were transfixated and ligated with a double ligature and the uterus freed. One suture through middle of vaginal vault. The incision (abdominal closed) and the vagina loosely packed with iodoform gauze pushed above vaginal roof for drainage on account of some slight venous oozing. The tumor weighed 25 pounds. This patient made a satisfactory recovery. Case 2. Patient, 43 years of age, had profuse uterine hemorrhages. Uterus as large as a five months' pregnancy from interstitial fibroid. Endometrium curetted and iodine injected without relief. Hysterectomy by the vaginal method. Recovery. Case 3. Aged 63 years. Diagnosis interstitial fibroid with carcinoma of cervix. The uterus reached the middle of the hypogastrium and was about the size of the preceding case. Its removal was easily effected in the same manner. Ligaments were secured with clamps. The fibroid, about the size of an orange, was not weighed. Recovery. Case 4. Patient, aged 44. Uterus enlarged from small fibroids. Vaginal hysterectomy, followed by recovery. Case 5. Patient, aged 35 years, diagnosis uterine fibroids, reaching to umbilicus. Recovery. Case 6. Patient, aged 42. Large uterine fibroid the size of an eight months' pregnancy. Vaginal hysterectomy. Case 7. Patient, aged 40. Diagnosis of subperitoneal fibroid attached to fundus. Same operation. Case 8. Colored woman. Fibroid affecting the body of the uterus and as large as a six months' pregnancy.

Dr. Howard A. Kelly of Baltimore made some remarks on the "Technique

of Supravaginal Hysterectomy." He described a new method for hysterectomy in removing the uterus, ovaries and tubes through the abdomen. It is a modification of the Baer method. He had tested it in about one hundred and fifty cases of all kinds, and had operated in the presence of hundreds of practitioners. While he had not heretofore described it, he had briefly referred to it before the section on Obstetrics and Diseases of Women at the Baltimore meeting of the American Medical Association.

Dr. Joseph Taber Johnson of Washington, D. C., followed with a paper entitled "Seventeen Cases of Hysterectomy." The first successful hysterectomy ever performed was done by Dr. Burnham of Lowell, Mass., in 1853. Kimball, who assisted Burnham in his first case, subsequently operated with success after a correct diagnosis had been made. In 1875, Kimball reported nine hysterectomies with three deaths. Burnham had then done sixteen hysterectomies with four deaths. These results were considered fairly good at that time. In 1878 Gusserow reported that up to 1866 Koeberle had lost all but eight out of forty-two hysterectomies, giving him a mortality of 81 per cent. Schroeder collected reports of 108 hysterectomies with a mortality of 85.3 per cent. Thomas' Diseases of Women reports 24 cases with 18 deaths. Storer, in 1874, reports 10 American hysterectomies, all died. From 1874 to 1894 many changes in technique, including asepsis, the Trendelenburg position, the intrapelvic but extraperitoneal treatment of the pedicle, the closure by suture of the separated edges of the broad ligament, drainage, when necessary, through the vagina after total extirpation, have all had their share in diminishing the mortality from 85.3 per cent. In the June number of the *Annals of Gynecology*, Cushing publishes a report of 1670 suprapubic hysterectomies done by American operators, with a mortality reduced to 13.8 per cent. One of the improved methods of widening the scope of this beneficent and magnificent operation and greatly reducing its mortality was introduced, advocated and practiced

by Dr. B. F. Baer of Philadelphia, who is quoted in Cushing's article as having operated 78 times with 71 recoveries and 7 deaths. Dr. Johnson presented his paper for the purpose of reporting 17 operations by Baer's method with 16 recoveries and one death. The three preceding papers were then discussed jointly.

*Dr. Henry O. Marcy* of Boston agreed with Dr. Johnson that the method of operating by the Koeberle clamp had been shown to be absolutely wanting in this type of operation; that it is not easier to do excepting in very few and rare cases; that it is ill-advised and subject to serious dangers. In reference to the operation described by Dr. Kelly, he desired to refresh the memory of the members that in 1880 he published a paper in which he reviewed the various steps and pointed out the advantages of the operation which is now known under the name of Dr. Baer. In the International Congress of 1881, he presented a second paper in which he emphasized the value of it. The advantage of leaving the stump was a great gain in the subsequent result, in that it left a sort of fixation point between the uterus, rectum and bladder. It is of value, again, in that it does not shorten the vagina—a question of paramount importance in reference to marital life and of the conditions that may follow in the subsequent history of the patient. He was sure that surgeons were working on the line of great and general improvement, and that when the technique of this operation has been developed more thoroughly, the time is coming when the removal of large fibroid tumors of the uterus will be accomplished with equal safety as the removal of large ovarian cystomata.

*Dr. Richard Douglas* of Nashville said one advantage of the procedure described by Dr. Kelly was that the bladder was out of the operative field, the surgeon not having to handle that viscous; that the operator could open the broad ligament and remove the intraligamentary fibroids without difficulty and without danger. Another important feature was that the risk of ligating the ureter was greatly reduced.

*Dr. W. E. B. Davis* of Birmingham believes that most surgeons are now inclined to accept the intra-abdominal method of operating, although it was still a question whether we shall have a pedicle or go in through the vagina. A very important point was with reference to the time of these operations. He had seen Dr. Kelly operate and admired his manual dexterity; but to take out the uterus in six or seven minutes meant very little, when it takes an assistant, or the operator himself, an hour or more to complete the balance of the operation. At the meeting of the American Medical Association he saw Dr. Kelly remove the uterus by the method he had described in something like seven minutes, but it took his (Kelly's) assistant one hour and twenty minutes to finish the operation. This was no reflection on Dr. Kelly's skill as an operator but he thought the matter of time should go on record in a little different way.

*Dr. A. Vander Veer* of Albany remarked that in 1889 he removed the uterus somewhat in the manner described, the case having been already recorded. He had done the operation only twice since. He uses the Koeberle clamp because he thinks he can do the operation much quicker, and has no reason to regret its use.

*Dr. A. M. Cartledge* of Louisville believes it is an advance in pelvic surgery to remove the uterus in badly septic cases, whereas formerly only the tubes and ovaries were taken out.

*Dr. E. S. Lewis* of New Orleans remarked that his experience with total hysterectomy for fibroids was restricted to the cases he had reported. The operations which he had performed up to last year were cases in which a partial removal of the uterus was effected, leaving a portion of the cervix. He could not but think, however, notwithstanding the majority of the gentlemen who had spoken upon the subject appeared to be advocates of the partial operation of leaving a part of the cervix, that total removal of the uterus was the best operation.

*Dr. Kelly* said, in reply to Dr. Davis, that when he spoke of removing the uterus in seven minutes or less, it did not

include closure of the wound, dressing, etc. He had never been so dishonest as to make the statement that the entire operation could be done in such a short space of time, nor would he like that impression made.

*Dr. Johnson* remarked, in reference to taking out the cervix, that it prolongs the operation and necessitates greater mutilation and more stitching and seems to be unnecessary in view of the successful cases that had been and are being reported. Patients get perfectly well without doing it. He concurred in Dr. Davis' statement that the time consumed in taking out the uterus did not amount to much, but that we should consider the matter from the time the first incision is made until the last stitch is inserted, the wound dressed and the patient off the table.

*Dr. Joseph Price* of Philadelphia contributed a paper entitled "Abdominal Hysterectomy." Among other things he said that had the same mortality attended the early ovariotomies that attended the first ventures in hysterectomy, there would have elapsed a longer period than forty or fifty years between the first successful ovariotomies and the date of the revival of the procedure. Both vaginal and supravaginal hysterectomy had been largely practiced by those who have given pelvic surgery most attention. They are the men who have contributed the most to perfecting the procedure. Abdominal hysterectomy is the one procedure indicated in all cases of intrauterine malignancy, where vaginal portions of the cervix are not involved, in all cases of uterine malignancy complicated with tubal and ovarian disease, and in cases of uterine fixation antedating the malignant development. Hysterectomy, vaginal or supravaginal, should be a simple, direct and complete operation in every detail. Where the operation is done with good surgical judgment and skill, there will be comparative immunity from all risk of dangerous hemorrhage and avoidance of sepsis. The method of procedure successful experience recommends as safe, the most satisfactory and complete in its results, is extirpation by lateral ligation, incision of the posterior vaginal fornix, circular in-

cisions of vagina to bladder, and approximating vaginal walls to and matching perineum, completes the simple procedure. This is the method with which others, as well as Dr. Price himself, have met with the best success.

## CORRESPONDENCE.

### THE HEALTH COMMISSIONER.

BALTIMORE, NOV. 27, 1895.

Editor MARYLAND MEDICAL JOURNAL:

*Dear Sir* :—In view of the great changes which are anticipated to shortly occur in the army of city employees medical men naturally ask the question: Will the present health commissioner remain in office, and if not, who will be his successor? Mr. Hooper is here confronted with a grave responsibility, and a responsibility, moreover, which is perhaps not sufficiently appreciated. It is to be greatly regretted that an office of such importance should be affected by political changes at all, as the incumbent is thereby prevented from devoting his entire energies to the work for which he has been selected. That the health department of the city should be placed beyond the reach of politicians is admitted by all fair-minded citizens.

The present health commissioner has been in office long enough to become thoroughly familiar with the workings of the department. He has done all in his power to further the welfare of the city from a sanitary point of view. While it is true that the health department, such as it is, cannot be regarded as a model department by any means, and one to be imitated by other cities, this is not the fault of its chief, but the fault primarily of the Mayor, the City Council and politicians. Reforms have been urged again and again by the present health commissioner. With what result? The health commissioner's report is written, printed and filed, but not read! The whole affair is merely a matter of form and might be dispensed with, as far as any practical good is concerned that is derived from the same.

Is it the fault of the health commissioner that the city of Baltimore is still without a hospital for the treatment of contagious diseases? Is it the fault of the health commissioner that our system of sewage is still one of the worst that can be imagined? Surely not. It would certainly be unfair to hold the servant responsible for the deeds of his masters.

Were the present health commissioner removed from office his place would only be filled by a man who must of necessity be unfamiliar with the management and the responsibilities of this most important department. An opportunity is here afforded the incoming Mayor of carrying out one of the great principles of Civil Service Reform, and of earning the gratitude, I am sure, of the entire medical profession by retaining in office a man who has performed his duties faithfully and efficiently, and in whom the medical profession has full confidence.

Above all, let the Mayor and City Council attend more closely to suggestions in sanitary reform. Baltimore is undoubtedly the great medical center of the United States and men are not wanting who are both willing and capable of acting as advisors in the management of this so sadly and unjustly neglected department.

I address these lines to your JOURNAL, trusting that they will be received in the spirit in which they have been written.

#### BELAIR MEETING.

BELAIR, Nov. 20, 1895.

Editor MARYLAND MEDICAL JOURNAL:

*Dear Sir:*—While not a great many physicians from Baltimore attended this session of the State Society, I think it may be justly called a successful meeting. The local profession attended in larger numbers than is usual at these meetings and three members of the Harford County Medical Association were down on the programme for papers. Dr. C. Birnie of Taneytown, one of the vice-presidents, occupied the chair on the first day and our indefatigable treasurer, Dr. W. F.

A. Kemp, the second day, showing that his talents as presiding officer were equal to his ability to collect dues.

Too much praise cannot be given to the Harford County Medical Association and the local profession of this place for the hospitality shown to all visiting members. Houses were thrown open and the excellent banquet given last night was tendered by that Association and all visiting physicians were the guests. Unfortunately, the fact that a banquet would be tendered had not been sufficiently announced and in fact no notice was made of it on the official programme, so that few visiting physicians were aware of this pleasure and consequently were not present at that time. Honorable Walter Preston not only welcomed the Faculty in the hall in the morning session, but at the banquet at night made another speech. Dr. Gorsuch made a very happy toast-master and speeches were numerous and witty.

On motion of Dr. John Morris of Baltimore, the tender and heartfelt sympathy of the members was extended to Dr. Michael in his present illness. This meeting had the usual effect of cementing the bonds of union between State and local society and all enjoyed the short visit in the hospitable town of Belair. Next week I will send you a report of the proceedings of this meeting.

The following physicians were present: Drs. J. R. Winslow, E. J. Bernstein, W. W. Russell, W. B. Platt, S. T. Earle, James A. Steuart, J. N. Mackenzie, James F. McShane, W. F. A. Kemp, John Morris, John Neff, W. B. Canfield, Hiram Woods, Jr., J. Mason Hundley, William Lee, A. K. Bond, William Lee Howard of Baltimore; Dr. C. Birnie of Taneytown; Drs. J. C. Butler, C. H. Hollingsworth, W. S. Archer, W. B. Munnikhuysen, J. W. Scott, E. Hall Richardson of Belair; Dr. O. B. Concord of Hickory; Dr. R. Opperman of Abingdon; Dr. John Sappington of Darlington; Drs. J. F. H. Gorsuch of Fork; W. L. Smith, Jarrettsville; C. C. Fite, New York; T. H. Brayshaw, Glen Burnie; W. W. Virdin, Lapidum; C. M. Ellis, Elkton; Silas Scarboro, Scarboro; Charles Bagley of Bagley.

## MARYLAND

## Medical Journal.

PUBLISHED WEEKLY.

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BALTIMORE, NOVEMBER 30, 1895.

THE attempt to enforce laws tending to make men better than they are meets with many obstacles. Human nature is the same everywhere; and ingenuity seems to be clever enough to evade the most carefully framed law.

The better part of most small towns has the welfare of its community at heart and with that idea, efforts are used to make and keep the community pure and moral. The avenues for occupation and amusement in a large city are such that while those inclined to dissipation and to indulge in it to their heart's content in reality are often distracted by other diversions, often of a more ennobling or less harmful nature, and that occupation that thus diverts at the same time elevates. In a small community where nothing goes on at night, and where all efforts to amuse and divert the idle mind meet

with the greatest obstacles, the natural tendency of men, young, old and middle aged, is to congregate at certain places, talk and eventually drink, and the drinker in a small place usually becomes a sot for the want of something better to do, while that same man in a city might become a useful and law-abiding citizen.

The towns and communities that have voted by a majority to have no saloons need not sit down and think that drinking has been stopped. Let anyone notice the character of freight and luggage that is brought to one of these prohibition towns on a train from a larger place. Usually it is in the shape of bottles and demijohns consigned to the prominent citizens and drug stores. Any stranger in these parts, especially on a Saturday night, will notice the large number of full demijohns arriving and will also wonder at the numerous drug stores, which seem to do a thriving business out of all proportion to the size of the place.

One town in Maryland with a population of about 800 has four drug stores, and in another place on the Eastern Shore of Maryland the drug stores do a thriving business. One great obstacle to the success of prohibition in these small places is, sad to say, the physicians, who unhesitatingly write for themselves and their friends and patients prescriptions for whiskey and other stimulants to the amount of a pint and a quart at a time and if it were not for these drink prescriptions, these drug stores, which are nothing more than bar rooms, would not be able to exist.

In one town several physicians have just been indicted for what is called illegal prescribing. It is a great temptation for physicians to give such prescriptions and many are obliged to do it or lose a large *clientèle*, but it is a shame to prostitute a noble profession to the plane of assistant barkeeper. Nothing short of combination can prevent this. It is not, too, always easy to make a distinction. There might be times when it was important to have stimulants and under that plea probably those indicted will contest any action brought against them. Many physicians may not believe in the cause of what is usually called temperance and may laugh at that apparent delusion prohibition, but they ought not to lend their aid in making drunkards of their fellow townsmen and thus increasing disease and crime.

This question is an important one and physicians who continue to use their profession as a means of helping on the liquor traffic should not only be indicted by grand juries and bear any just penalty which may be inflicted, but they should lose caste among their professional colleagues and their position in their representative societies.

\* \* \*

ADVANCES in scientific methods of research have led to many practical results, not the least of which in one case is *Malaria and Typhoid Fever.* the ability by skilled persons to differentiate between malaria and other diseases with chills simulating malaria.

Osler in the *Medical News* shows how false have been the mortality statistics of malaria and typhoid fever, simply because so many diseases have been diagnosed as malaria, which were not that disease. Too often the diagnosis is made from the chills alone, and the absurdity of this is shown in the United States Census Reports, according to which more deaths occurred in Baltimore, New York and Brooklyn from malaria than from typhoid fever, a statement which will be read with astonishment by those who know how rarely fatal malaria is in proportion to the number of cases that occur.

In opposition to this view comes the statement of Dr. W. Moser in the *Medical Record* on the alleged parasite of malaria, in which he says that these bodies within the blood cells are not parasites, but degeneration products. Osler says that the best guarantee of a truth is the wisest men's acceptance of it. Now men who know something of bacteriology and also clinical medicine have accepted Laveran's work and have proved it, and those who have not the ability to comprehend it should not refuse to believe. Life is too short for each worker to go over and prove each step of every other man's work, and when workers of acknowledged ability make a statement, it should not be turned down until other persons equally competent question it and prove its falsity.

Dr. Richard C. Newton recorded the result of his observation in the *International Medical Magazine*, proving to his mind the aerial as well as the aquatic transportation of malaria. Osler lays down two postulates:

1. That the diagnosis of the malarial fevers

can be made with certainty by the blood examination.

2. That an intermittent fever which resists quinine is not of malarial origin.

He also says that anyone who understands the methods and with a little experience can demonstrate the presence or absence of the organism of malaria. After showing the incorrect registration of statistics in many places in attributing deaths to malaria, which were undoubtedly due to other causes, he says:

The conclusion of the whole matter may be thus briefly expressed—the mortuary bills dealing with malaria are false, due either to ignorance or to wilful deception on the part of those who make the returns. Malaria is a disease that now rarely kills in the large towns on the Atlantic seaboard, and it behoves the profession to abandon the practice of making a careless diagnosis of the disease in every case of obscure fever which proves fatal, and the Medical Board should refuse to receive a death certificate signed malarial fever without more specific details than have heretofore been demanded.

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IF there is anything in hypnotism it is strange that the profession has not taken more interest in it, and if it is

*Hypnotism.* a difficult subject, as many subjects in the domain of medicine are, it is a wonder that more men have not studied it with true scientific zeal. That they have not done this with few notable exceptions is very evident.

With the exception of the French schools who have exploited this so-called therapeutic means and some perverted Germans, the few who have taken hold of it find little more than they expected and see the repetition of an experience of years ago when this same craze seized upon the profession and the public.

A fad in medicine, as in everything else, appears on the horizon and finds its champions too often in men who like the flare of trumpets and the fame of the charlatan. Then, like other things not genuine, it cannot stand the test of experience and the investigation of an unbiased mind and the stick falls as swiftly as the rocket went up.

Such crazes do no good, work much harm and should not be encouraged unless they have a firm basis and are shown to belong to the realm of genuine therapeutics.

**MEDICAL ITEMS.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending November 23, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		21
Phthisis Pulmonalis.....		21
Measles.....	170	
Whooping Cough.....	1	
Pseudo-membranous Croup and Diphtheria. }	25	15
Mumps.....	1	
Scarlet fever.....	12	
Varioloid.....		
Varicella.....	5	
Typhoid fever.....	4	2

The fate of the *Index Medicus* has been decided.

The new French ministry includes three physicians.

The Sir Andrew Clark memorial fund is said to be a failure.

Dr. Wirt A. Duvall has removed from 529 North Fulton Avenue to 1609 Edmondson Avenue.

Physicians in Baltimore will have ample opportunity to apply for municipal and State positions.

The committee to erect a monument to Huxley are undecided whether to erect a statue or found a scholarship.

The New York Pasteur Institute will have a suburban branch on the Erie Railroad and the station will be called Pasteur.

The prevalence of Asiatic Cholera at Moscow may compel the next International Medical Congress to seek another place of meeting.

The North Texas Medical Association will meet in Greenville, Texas, Tuesday, Wednesday and Thursday, December 10, 11 and 12, 1895.

Both the German and the Russian governments have issued regulations fixing the tariff of physicians. Germany is more liberal in the fees than Russia.

If the daily papers tell the truth, a member of the State Society has been indicted by the

grand jury of his town for illegal prescribing, which means prescribing a drink of whiskey in a prohibition town.

The *American Journal of Surgery and Gynecology* has been removed to St. Louis, from which place the December number (Vol. VIII, No. 1) is just issued. Dr. Emory Lanphear, Professor of Surgery in the Woman's Medical College, has been appointed editor in chief.

The New York State Medical Association, which was in session three days last month, elected the following officers: President, Darwin Colvin of Clyde; Vice-Presidents, C. H. Glidden of Little Falls; Thomas Wilson of Claverack; S. G. Seaman of Seneca Falls, J. R. Vandevere of New York City; members of the Council, W. H. Robb, George E. McDonald, J. G. Truax, E. M. Moore, Jr., and W. L. Ayer; Secretary and Treasurer, E. D. Ferguson of Troy.

The Second Quinquennial Prize of One Thousand Dollars under the will of the late Samuel D. Gross, M. D., will be awarded January 1, 1900. The conditions annexed by the testator are that the prize "Shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens." It is expressly stipulated that the successful competitor, who receives the prize, shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery. The essays, which must be written by a single author in the English language, should be sent to Dr. J. Ewing Mears, 1429 Walnut Street, Philadelphia, before January 1, 1900. Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay. The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year. The committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

## WASHINGTON NOTES.

The Clinico-Pathological Society held its regular meeting on November 19, the President, Dr. H. B. Deale, in the chair.

It was moved and carried that the papers read before the Society and the transactions should be sent to the MARYLAND MEDICAL JOURNAL, as formerly.

The question of having a banquet was discussed. Dr. A. A. Snyder presented some fecal concretions, removed post-mortem, in a case of appendicitis.

Dr. Louis Mackall showed a patient to the Society, with a remarkable conjunctival growth from the right lower lid. It was discussed by Dr. W. H. Wilmer, who considered it sarcomatous.

Dr. W. S. Bowen presented cases and specimens of pus tubes and diseased ovaries.

The essayist of the evening was Dr. R. W. Baker, who presented an interesting paper, entitled "The Cirrhotic Kidney." It was discussed by Dr. A. A. Snyder and others.

The Medical Society of the District of Columbia met on Wednesday evening, November 20, Dr. Samuel C. Busey, the President, in the chair. Dr. H. W. Beatty reported a case of "Dermatitis Exfoliativa," which was discussed by Dr. McGuire.

Dr. Behrend reported a case of "Rabies," and Dr. D. E. Salmon, of the Bureau of Animal Industry, read a paper on the "Prevalence of Rabies in the District of Columbia." It was discussed liberally by Drs. V. A. Moore, Walter Read, Forwood, Schaeffer, A. A. Snyder, Lovejoy, and others. Dr. G. N. Acker presented a case and specimen of "Endocarditis in an Infant."

## PUBLIC SERVICE.

OFFICIAL LIST OF CHANGES IN THE STATIONS  
AND DUTIES OF MEDICAL OFFICERS.

## UNITED STATES ARMY.

*Week ending November 25, 1895.*

Leave of absence for four months, to take effect about December 10, 1895, is granted Captain George McCreery, Assistant Surgeon.

Powell Conrad Fauntleroy appointed to be Assistant Surgeon, with rank of First Lieutenant, November 15, 1895.

First Lieutenant Irving Wallace Rand, Assistant Surgeon, will report in person, with-

out delay, to the president of the Army Medical School for the course of instruction prescribed in General Orders No. 78, September 22, 1893, from Adjutant General's Office.

Major Justus M. Brown, Surgeon, promoted to be Deputy Surgeon General, with the rank of Lieutenant Colonel, November 15, 1895.

Captain Daniel M. Appel, Assistant Surgeon, promoted to be Surgeon, with the rank of Major, November 15, 1895.

Lieutenant Colonel Joseph R. Gibson, Deputy Surgeon General, retired November 15, 1895.

## UNITED STATES NAVY.

*For One Week ending November 23, 1895.*

Medical Director P. S. Wales ordered to duty as member of the Retiring Board, Washington, November 25, in addition to his present duties.

Passed Assistant Surgeon R. P. Crandall detached from the Naval Laboratory and ordered to the Naval Hospital, New York.

Passed Assistant Surgeon Philip Leach detached from the Naval Hospital and ordered to the Naval Laboratory, New York.

## UNITED STATES MARINE SERVICE.

*Fifteen days ending November 15, 1895.*

C. S. D. Fessenden, Surgeon, ordered from Salem to Boston, Mass., for physical examination, November 14, 1895.

D. A. Carmichael, Passed Assistant Surgeon, relieved from duty at St. Louis, Mo., and directed to proceed to Vineyard Haven, Mass., and assume command of Service, November 1, 1895.

S. D. Brooks, Passed Assistant Surgeon, relieved from duty at Chicago, Ill., and directed to proceed to St. Louis, Mo., and assume command of Service, November 5, 1895.

J. H. White, Passed Assistant Surgeon, granted leave of absence for twenty-three days, November 5, 1895.

T. B. Perry, Assistant Surgeon, granted leave of absence for thirty days, November 11, 1895.

J. O. Cobb, Passed Assistant Surgeon, to proceed from Port Townsend to Port Angeles, Wash., as Quarantine Inspector, November 1, 1895.

J. B. Stoner, Passed Assistant Surgeon, to proceed from Detroit, Mich., to Baltimore, Md., for temporary duty, November 1, 1895.

C. H. Gardner, Assistant Surgeon, to proceed from San Francisco, Cal., to Chicago, Ill., for duty, November 5, 1895.

Seaton Norman, Assistant Surgeon, to proceed from Baltimore, Md., to New Orleans, La., for duty, November 1, 1895.

A. R. Thomas, Assistant Surgeon, to assume temporary command of Service at St. Louis, Mo., November 1, 1895.

J. B. Greene, Assistant Surgeon, to proceed from Vineyard Haven, Mass., to Baltimore, Md., for duty, November 1, 1895.

**BOOK REVIEWS.**

**MODERN MATERIA MEDICA**, with Therapeutic Notes. For the Use of Practitioners and Students of Medicine. By Dr. Otto Roth. Seventh Edition. Revised by Dr. George Smith, Wurzburg. One volume of 467 pages, octavo, muslin binding. Price, \$2.00. New York: William Wood & Co. 1895.

This book, which must be of value in Germany to have reached its seventh edition, seems to make its bow to this country without preface or introduction and no translator is named. Many new remedies have been omitted and the dosage is not altogether such as is used in this country. The drugs and diseases are alphabetically arranged. In view of so many excellent works of this kind on the market, the student can well afford to do without this one.

**FOSTER'S PHYSIOLOGY**. Text-book of Physiology. By Michael Foster, M. D., F. R. S., Prelector in Physiology and Fellow of Trinity College, Cambridge, England. New (sixth) American edition with notes and additions. In one handsome octavo volume of 922 pages, with 257 illustrations. Cloth, \$4.50; leather, \$5.50. Philadelphia, Lea Brothers & Co. 1895.

The previous editions of this important work have been noticed in these columns. This volume has been condensed in places for the student's use and various alterations and additions have been made. The histology of the nervous system, as well as the chemical appendix, have been retained. The more important additions are put in brackets ([ ]). The illustrations have been re-engraved. The American editor is not named.

**REPRINTS, ETC., RECEIVED.**

**Extrication and Colotomy in Cases of Carcinoma of the Rectum**. By Lewis H. Adler, Jr., M. D., Philadelphia. Reprint from the *Medical News*.

**Antiphthisine, Report on Professor Klebs' New Tuberculin Derivative and Some of the Cases Treated**. By Charles Denison, A. M., M. D., Denver. Reprint from the *Medical Record*.

**Favorable Results of Koch's Tuberculin Treatment in Tubercular Affections that are not Pulmonary**. By Charles Denison, A. M., M. D., Denver. Reprint from the *New York Medical Journal*.

**CURRENT EDITORIAL COMMENT.****INSTINCT VERSUS REASON.**

*Western Reserve Medical Journal.*

THE duty of a physician to his patients has, of late years, owing in part to the complexity of modern life, undergone a certain change. In early days incantations and exorcisms were replaced by simples and drugs, and in their administration the element of superstition was not, and perhaps is not yet, entirely eliminated. In addition to medicines, the physician must now advise in regard to exercise, diet, sleep, in fact, mode of life in general. The question at once arises, how far can a patient be trusted to follow his own tastes and inclinations.

**RESPONSIBILITY IN PHTHISIS.**

*The Lancet.*

EVERY suitable opportunity should be taken of impressing upon patients that the proper time for climatic change is when the disease is threatening rather than actually declared. It is, we conceive, the simple fact, deplorable as it is, that at present in the vast majority of cases the proper time for applying climatic treatment with effect is allowed to pass, and that treatment is commonly reserved for a stage of the disease when its success is always precarious and its failures are many. On the other hand, its success in the early incipient stage of the malady is often great and brilliant. Early diagnosis is of supreme value in this matter and cannot be too earnestly insisted upon.

**MONEY AND UNCLEAN HANDS.**

*Medical Record.*

MONEY is proverbially filthy, but whether constant handling of small coin is accountable for the disgustingly grimy condition of the hands of street car conductors is questionable. It is certain, however, that, as a class, their hands are conspicuously unclean. Many passengers may be observed, who, in paying their fare, avoid touching them as they would the plague. It would probably be somewhat ahead of the times for boards of health to impose personal cleanliness upon men who come in such close contact with the public, but the superintendents of all railway lines might be supposed to take a little pride in the neat and cleanly condition of their employees. A small outlay for soap, and an insistence upon its frequent use, would add much to the comfort of every community.

# MARYLAND MEDICAL JOURNAL

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## ORIGINAL ARTICLES.

### NOTES ON THE TREATMENT OF PLASTIC IRRITIS.

READ BY TITLE AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL  
FACULTY OF MARYLAND, AT BELAIR, NOVEMBER 19 AND 20, 1895.

By Harry Friedenwald, A. B., M. D.,

Associate Professor of Ophthalmology, College of Physicians and Surgeons, Baltimore.

THE frequency and importance of plastic iritis demand a thorough knowledge of its treatment on the part of the general practitioner. Certain fundamental facts are well known. The most important of these is the necessity for the instillation of atropia, which is indicated in all cases.

The action of this drug is twofold. First, it diminishes the vascularity of the iris and ciliary body, and thus reduces the inflammatory action; and secondly, it dilates the pupil, and thus prevents the formation of synechiae. The use of even this important remedy has its limitations. One of the most common, unpleasant results due either to excessive use of the drug, or to an idiosyncrasy of the patient is its toxic action from the absorption of the atropine by the mucous membrane of the conjunctiva and nasal passages.

We may disregard those cases in which the only toxic symptoms are dryness of the throat, flushing of the face, and perhaps slight febrile symptoms, but we occasionally have such occurrences as the following:

Mr. S. had been under treatment for some time for plastic iritis, without showing any but the local effects of the drug. It became necessary to instill the atropine frequently (every three hours). An urgent message was sent to me;

when I arrived I was told that the patient had had a severe chill, and had been delirious from 3 P. M. to 2 A. M. A physician living near-by had administered bromide and quinine to relieve what he thought was a malarial chill. The patient had been very weak, his skin hot and throat dry and he was afterwards unable to recall any of the incidents that had occurred. On the following day he felt quite well again. When we consider that the solution ordinarily used is made up of one grain of the sulphate of atropine to two drachms of water—in other words, that every drop contains  $\frac{1}{120}$  grain of the alkaloid—it will not seem at all remarkable that toxic symptoms should sometimes make their appearance. In some individuals the flow through the lachrymal duct is very free. In all such cases we may prevent the alkaloid from reaching the nasal cavities, by pressing upon the inner angle of the eyelids while the drops are being instilled, thus closing the lachrymal canaliculus.

Another very disagreeable effect of the continued instillation of atropine is a peculiar form of conjunctivitis. The eyes are irritated and painful and the conjunctival surface is studded with small granulations. Some attribute this to the chemical action of the alkaloid, others to the presence of micro-orga-

isms, which abound in solutions that are not frequently sterilized. The latter view is probably correct and serves to warn us from using contaminated solutions. When the affection has made its appearance we may have to cease instilling atropia, to substitute other mydriatics and to use astringent solutions.

An equally unpleasant complication arising from the long-continued use of atropia is an eczema of the eyelids, often spreading over the cheek. In some it is a moist eczema, the skin becoming denuded and very red, in others it is of the dry, scaly form. It may be associated with atropine conjunctivitis. I am inclined to believe that it owes its origin to the same cause as the conjunctivitis. In a few cases which have recently occurred I have replaced the solution by an ointment made up of lanoline and sulphate of atropia in the same proportion as the solution. This had always had the desired effect of causing the rapid disappearance of the eczema.

The frequency with which the salve or the solution has to be applied varies with the degree of the inflammation and the state of the pupil. Our object is to dilate the pupil as far as possible and to keep it dilated; if two or three applications daily will give this result we need not use it more frequently; but the pupil must be kept dilated and, if necessary, the instillation or application must be made every hour or two. I have rarely been obliged to substitute other mydriatics for atropine, but I have occasionally found the combined use of atropine and cocaine very beneficial; this, however, would not lead me to advise the frequent combination of these remedies in the treatment of iritis.

An important fact which is not generally known is that atropine may be used for too long a time. We frequently see cases of iritis in which the inflammation has lasted for some time and in which the pupil is bound down by strong adhesions; the latter had formed before the mydriatic was used and even the most persistent use of atropine will not tear them. In these cases atropine may be used for months and the pupil remains contracted and irregular, and besides this the inflammatory symptoms will

persist to a greater or less degree. It is difficult to explain this fact, but it impresses us as though the irritation depended upon an unequal tension on the iris tissue, due to the adhesions of the iris on the one hand and the dilating force of the atropia on the other. Almost as soon as we cease instilling atropine the irritation subsides. These cases are very interesting and I will therefore relate one recently treated by Dr. W. T. Riley and myself.

Mrs. C. had a very intense double iritis. The right eye had been cured without any adhesions before I saw the patient. On June 13, 1895, the left eye was intensely inflamed; there were numerous firm adhesions of the iris to the lens; the pupil was slightly and very irregularly dilated. (There were numbers of deposits upon the posterior surface upon the cornea as well as infiltrations in the corneal tissue.) June 28 she was considerably better but the synechia were still present and the outer surface of the lids was thick, scaly and furrowed. The patient presented a typical case of atropine eczema. The atropine solution was therefore replaced by atropine in lanoline. About the end of July the patient returned; the inflammation had subsided, but there was still considerable irritation. The atropine was withdrawn, even though there were numerous synechiae, and in a very short time the eyeball became white and the pain disappeared.

The use of the natural, or still better, the artificial, leech is often followed by great improvement, both as to pain and as to the congestion of the eye. We thus occasionally see an iris which has previously resisted the action of atropia rapidly dilate after the abstraction of blood.

Hot applications to the eye are also very beneficial in reducing the inflammation and diminishing the pain. These can best be made by applying cloths wrung out in hot water to the eye. The use of dry heat, even that produced by the little Japanese boxes, is scarcely as satisfactory.

One of the main objects of treatment, as has been said before, is to dilate the pupil and to keep it dilated until all

signs of inflammation are over. Keeping this in view, all conditions should be avoided which will tend to contract the pupil. The most important is to avoid bright light, but any effort at accommodation is likewise injurious. It is best, therefore, to keep the patient in a dark room or to bind up the inflamed eye and to have the patient wear smoked glasses over the healthy eye. It is scarcely necessary to remark that exposure of one eye to light produces contraction of the pupil of its fellow.

Plastic iritis is almost always due to a primary constitutional disease and in our treatment this fact dare not be forgotten.

The primary disease with which we are most frequently concerned is syphilis, especially in the secondary stage. Mercurial inunctions are, therefore, of greatest benefit. In this connection it may be well to call attention to the fact that in rare cases the iritis precedes all the other secondary symptoms. A small number of such cases are on record. One case of this kind has come under my observation. It is the following:

Mrs. P. began treatment for plastic iritis early in December, 1893; close inquiry did not reveal any signs of syphilis, but there was some complaint of rheumatism; atropine, locally, and salicylate of soda were prescribed and the patient recovered in less than two weeks, but the iritis soon recurred and again salicylate of soda and also iodide of potash were administered. (December 23, 1893). During the beginning of January the inflammation had entirely disappeared and local treatment was discontinued. January 20 the patient returned with a third attack and I detected a slight macular eruption over limbs and body which, I was told, had made its appearance three weeks before. According to this statement, the iritis had preceded the eruption by at least four weeks.

While vigorous specific treatment is without doubt necessary in all cases of syphilitic iritis, this treatment is by no means abortive. We frequently see cases in which, during, or immediately after, the thorough specific treatment of

iritis of one eye, the other eye is attacked by the same inflammation.

Alexander and others have pointed out that the treatment of iritis due to tertiary syphilis should be based upon iodide of potash and tonics, like other lesions of this stage. This form of iritis is very much less frequently met with than the secondary form; in fact, pure cases are rare and many that are seen are due to the persistence of old adhesions that were formed during the secondary stage.

For the treatment of iritis due to rheumatism, we must depend upon salicylate of soda. The effect of this drug in acute rheumatic iritis is very marked, but its use is not limited to these cases. It is highly beneficial in other forms, such as the syphilitic, the diabetic, etc. As an example, let me refer to the case of Mrs. G., who had had severe diabetic iritis in which atropia, hot applications, etc., had been used for about two weeks without relief of either inflammation or pain; the administration of twenty grain doses of salicylate of soda was followed by the almost immediate disappearance of the pain and the other signs of iritis. The same remedy is likewise extolled by some of our colleagues for its beneficial effect in the ordinary acute form of syphilitis iritis.

Another agent that yields the most beneficial results in acute iritis is jaborandi or its alkaloid, pilocarpine; its effect is at times almost marvelous. In the case of Mr. N., who had an acute iritis of the severest type, due to gonorrhea, the intense pain and the other violent symptoms resisted hot applications, atropia, etc., but disappeared almost immediately after a thorough action of the fluid extract of jaborandi.

There are rare complications of iritis which require special treatment. As an example we may mention the simultaneous occurrence of glaucoma, which would require an iridectomy. The same operation should always be performed early in those cases of extensive adhesions of the iris to the lens in which there is any sign of secondary glaucoma or in which their presence tends to produce recurrent attacks of the iritis.

## CHRONIC BRIGHT'S DISEASE.

READ BEFORE THE ALLEGHENY COUNTY MEDICAL SOCIETY, SEPTEMBER 17, 1895.

*By J. E. Rigg, M. D.,  
Pittsburg, Pa.*

UNDER this head we may consider three different diseases of the kidneys, each having a pathology of its own ; each variety beginning in a particular part of the organ, and extending to the other structures secondarily.

There is, therefore, disease originating respectively in the uriniferous tubules, in the blood vessels, and in the fibrous stroma. That which originates in the tubules is always inflammatory in character. It may be acute or chronic. That which begins in the vessels consists of a peculiar degenerative change, sometimes called amyloid degeneration. That which begins in the stroma proper is by some considered to be inflammatory, and by others to be hypertrophic in character.

We have, then, the inflammatory, affecting the tubules, and secondarily the stroma ; the waxy or amyloid, beginning in the vessels ; and the cirrhotic, originating in the fibrous stroma.

The inflammatory type may begin acutely, or it may be from the first chronic in character. It is usually caused by exposure to cold, the action of certain drugs, such as alcohol, cantharides, turpentine, copaiba, carbolic acid, chlorate or nitrate of potash, phosphorus and arsenic.

The infectious diseases may also be considered causes ; as scarlatina, typhoid fever, typhus or yellow fever, diphtheria, pregnancy, meningitis and erysipelas. In scarlatina it usually develops late, eighteen to twenty days from the beginning of the disease. In most other diseases it will be found in the early stages, and is more the result of the impression made on the nerve centers than to the specific action of the poison. A burn on the surface, if extensive, sometimes causes nephritis. Inflammatory changes may extend up from the bladder through the ureters

and pelvis of the kidney and excite the disease. Micrococci are thought by some to be a cause.

The waxy or amyloid degeneration may be caused by any of the exhausting diseases, phthisis, syphilis, suppuration in joints, bones, etc.

The cirrhotic or interstitial nephritis may be caused by the long-continued use of alcohol, gout, continued mental strain ; and it is evident that there are many cases the causes of which are unknown to us.

The anatomical changes in the inflammatory type are, in the first stage, an enlarged and deeply congested kidney ; the capsule smooth and transparent, easily removed ; the cortex bluish red ; the Malpighian bodies appear like small dots of blood ; small spots of blood are almost always found in the cortex ; the medullary substance is greatly congested ; the organ as a whole is soft and brittle. As the disease advances, the organ becomes more pale, the surface more mottled, the tubules are full of epithelium in a granular state. Later on the organ becomes smaller, sometimes going below the normal size ; it is more firm, not so easily broken down. In this stage we have the fibrous stroma involved. Secondary changes may take place in the heart. First, dilatation, quickly followed by hypertrophy.

In the waxy or amyloid form we may have at first what seems to be a healthy kidney, but by the use of iodine we get a reaction which indicates a change in the Malpighian tufts and small blood vessels. By the microscope the stroma and tubules are found to be normal. Later the cortex seems to increase and is paler ; the stroma more dense than normal, and finally a contraction of the whole organ to sometimes less than half the usual size.

In the cirrhotic or interstitial form we

have a disease the progress of which is much slower. In the early stages, the organ is of full size; the capsule more adherent; the surface somewhat uneven and may present cysts; the cortex relatively enlarged by increase of the stroma; no change in the blood vessels or tubules. Later on the organ will be much contracted, perhaps to one-fourth its size; the capsule cannot be stripped off without tearing the organ; the surface uneven and granular and of a reddish color; on section the cortex relatively diminished, dense and firm, almost fibrous. The tubules atrophied, due largely to the contraction, and cysts usually are numerous.

It is well then to remember that in all three forms of Bright's disease we may have, if the case lasts long enough, a small contracted kidney, and that one form will not continue long without developing to some extent the pathology which belongs to one of the other varieties.

The symptoms of the inflammatory type are the decrease in the amount of urine, the abundance of albumen, and the edema of the skin, usually found about the eyes and face in the morning, and somewhat in the lower limbs in the evening, if the patient is out of bed. The urine may, if the disease begins suddenly, contain blood, and usually does contain casts, mostly of the epithelium; the urea is diminished, the specific gravity reduced, unless the quantity of water is relatively small; the pulse is very little quicker than usual and temperature not much elevated; more or less nausea; general feeling of debility with pain in the loins; possibly some tenderness over the kidneys; a slight sense of chilliness, not severe, but continuous and out of proportion to the elevation of the temperature. In cases where there is a sudden suppression of urine, and sometimes where there is not, we have a very severe line of symptoms develop: That of coma, convulsion, or delirium, according to the type it may select; as what we call uremia may have either of the three types. Often two or more combined, but one will be found more prominent than the other.

I have seen cases where the delirium was the only marked nervous symptom, but the convulsive type is most common. The urine contains as crystals, uric acid, urate of soda and oxalate of lime; as formed substances, blood globules, casts of almost all varieties, but, as stated, the epithelium the most common, renal epithelium and round cells.

Later in the course of the disease, the urine is more abundant, does not contain blood, not so many casts, but still remains low in specific gravity; sometimes I have seen it fall to 1001. The dropsy may continue, but there may be a general letting up of the symptoms and the patient feels that he is getting well, and I do not think this is an improbable result in this type of the disease, providing we can have the case under complete control for a sufficient time and before the pathology has extended to other than the uriniferous tubules, as it will do if the disease progresses.

In the waxy or amyloid form the onset is gradual and insidious. The history of some wasting malady, as phthisis, the suppuration of bones or joints, followed by an excessive flow of urine of low specific gravity and pale in color, containing little or no albumen at first and but few tube casts with no dropsy, enlargement of the liver and spleen. The anemic condition of the blood, gradual failing of the strength of the patient, partly from the diseased kidneys, and partly from the condition which gave rise to it, gives us a condition which justifies the diagnosis of amyloid degeneration.

In the cirrhotic or interstitial form, the onset is more gradual, and it may exist a long time without manifesting itself by any particular symptoms.

Our attention will often be directed to the kidneys by the dyspeptic symptoms, the frequent headaches, the blindness due to retinitis, and the heart complication. It is found more frequently between the ages of twenty and fifty years. It is rare in childhood. Men suffer more often than women. The loss of vital fluids, malaria, syphilis, abuse of alcohol, and extreme mental exertion,

may tend to develop this disease. It is my belief that mental exertion is a much more common cause than is generally supposed. The urine is very scanty and contains but little albumen at first, the skin is usually swollen and the heart becomes hypertrophied; there is very little or no general dropsy. The gastric catarrh, diarrhea, anemia, dyspnea, bronchitis, edema of the lungs, headache and the characteristic retinal condition make the diagnosis easy.

The prognosis is most unfavorable in this type, death usually being from uremia or some of the complications with the heart or lungs. The following table is submitted by Southeby, comprising one hundred and forty-one cases of the inflammatory, and three hundred and fifty-eight of the cirrhotic, as the autopsy showed.

Inflammatory (Parenchymatosus.)	Cirrhotic (Interstitial.)
Dropsy in . . 75 per ct.	Dropsy in . . 24 per ct.
No dropsy in . . 25 "	No dropsy in . . 76 "
Heart normal in . . 47.5 "	Heart normal in . . 6 "
Death from uremia . . 27 "	Death from uremia . . 50 "
Phthisis in . . 8 "	Phthisis in . . 11 "

The diagnostic symptoms in the inflammatory variety would be diminution of urine, abundance of albumen and epithelium, tube casts, diminution of urea and large amount of dropsy.

In the waxy, large amount of urine from the first, little or no albumen, absence of dropsy, amyloid degeneration in other organs.

In the cirrhotic or interstitial, insidious commencement, gradual development of vascular and cardiac changes, in the latter stages increased flow of urine.

The prognosis is grave in all forms, although less unfavorable in the inflammatory than the other varieties. There is more immediate danger in this form, but if it is recognized early and the patient will place himself under proper care, and receive intelligent treatment, there is a chance for his ultimate recovery. The chances grow less as the disease advances.

With the waxy and cirrhotic forms the prognosis is bad from the first, although life may be prolonged for a long time. The treatment of this disease

will depend largely on the stage of the disease and the variety that is believed to exist.

In the inflammatory, if in the early stage, the arrest of the disease is the object to be sought. This is best accomplished by the patient placing himself in bed, although he may feel that this is unnecessary. The advantages gained are that the patient is given rest and is protected from drafts and sudden changes which tend to increase the congestion, and the skin is more active. When out of bed the protection of the body by proper clothing is important. The diet should be milk in large quantities; cereals and starches to give variety; meat and eggs should not be allowed. The care in diet and protection of the body should not be relaxed when the more urgent symptoms pass off, as we may then expect to have a relapse and the disease will progress; but it should be kept up until all trace of the disease has disappeared. This may require months. It is not the intention to require the patient to remain in bed all this time, but to return upon the first evidence of cold or chilly sensation. Counter-irritation should be kept up over the kidneys. My own choice is dry cups followed by prolonged use of iodine.

The bowels should be kept open, but not purged. The kidney in this form should be washed out so as to free the uriniferous tubules.

For the bowels, the compound jalap powder together with calomel acts very well. Elaterium may be used if there is much dropsy, but generally the jalap and calomel will, I believe, answer better. I do not object to giving one grain of the calomel three times a day for three days, then rest from it for one to two weeks, and after a time leave it out entirely. For the kidneys, digitalis together with lemonade, makes, perhaps, the safest and best diuretic.

For the skin, the proper use of pilocarpine and the steam or vapor bath meet the indication. To relieve the inflammation and also to relieve symptoms of urea the use of veratrum viride has been most satisfactory in my hands.

The proper use of opium will do great good to relieve the urgent symptoms at the time and bridge it over until you can apply other treatment.

In the waxy form, the most important thing is to seek to remove the cause, if it can be ascertained, and support the patient.

In the cirrhotic form, symptomatic treatment is perhaps the best to follow. I have seen marked improvement follow the relief of a chronic bronchitis and by aiding a weak heart. In this form the diet and care of the body is of the utmost importance. Not from a curative standpoint, but that the patient may enjoy a fair degree of health and his life be prolonged.

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### SOCIETY REPORTS.

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#### MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

SEMI-ANNUAL MEETING HELD AT BELAIR, MD.,  
TUESDAY AND WEDNESDAY, NOVEMBER  
19 AND 20, 1895.

Dr. C. Birney, Vice-President, in the chair and Dr. A. K. Bond, Secretary pro tem. After an Address of Welcome by Hon. Walter Preston of the Belair Bar and by Dr. W. L. Smith of Jarrettsville, President of the Harford County Medical Association, Dr. C. Birnie replied on the part of the Faculty.

"The Surgical Treatment of Laryngeal Tuberculosis." This was the subject of remarks by Dr. John N. Mackenzie of Baltimore. He referred to the papers read before the American Laryngological and British Laryngological Societies on this subject. Krause of Berlin and Hering of Warsaw had done the best work on this subject. The surgical treatment of tuberculosis of the larynx is carried out by total and by partial curettement of the lesions with the application of lactic acid. Usually the tissues are first curetted out with specially prepared instruments and the acid is rubbed in. The Germans use a fifty per cent. solution of lactic acid, while others use it pure and some operators rub the acid in without curetting,

provided ulcerations exist, for the acid will not go through the intact mucous membrane. The tissues may also be injected with a solution of the acid. The results of this treatment by curetting and lactic acid are wonderful. The ulcers may heal even when the lungs are far gone. When the infiltration is circumscribed and in the epiglottic portions the tissue may be excised. The subsequent treatment is to paint the surface with pyotanin, or lactic acid may be used. Sometimes the whole diseased area is not easy to get at. These wounds generally heal very well. Sometimes there is hemorrhage, but this may be stopped by application of equal parts of lactic acid and perchloride of iron. Some operators use the scissors to cut off the diseased part when this is possible and some use electrolysis, putting one pole in the lesion and the other on the neck. The galvano-cautery is also used. In stenosis, intubation has been suggested, and tracheotomy is a last resort in some conditions, but this is only justifiable to prevent suffocation. Thyrotomy has been practiced under some circumstances and even it has been proposed to extirpate the whole organ. As the disease is rarely primary in the larynx, only about five cases having been reported, this operation is not advisable. Such cases usually die. Most observers agree that the effect of this treatment is beneficial to the lung disease and a few have the opposite view, but it seems rational that it must do good. It does not effect a cure, but it does prolong life. Relapses occur. In hectic fever and when the disease is diffuse this operation is contra-indicated.

*Dr. William B. Canfield* thought these facts very interesting for the specialist and general practitioner. He would like to know something of the technique of these operations. How strong was the cocaine solution used before curetting and how were the applications made.

*Dr. Mackenzie* said this was very simple. The cocaine was in ten to twenty per cent. solution and the pyotanin used was a two per cent. solution. Special instruments had been devised

by Hering of Warsaw and he had sent for some, but the curetting and the application of the lactic acid was not difficult.

*Dr. Hiram Woods* of Baltimore then read a paper entitled "Management of Advancing Corneal Ulceration in Gonorrhreal Ophthalmia. (See page 112.)

*Dr. J. M. Hundley* of Baltimore read a paper entitled "Tears of the Cervix Uteri; Their Significance and Repair." (See page 109.)

*Dr. John Morris* of Baltimore said this was a most sensible and practical paper. He had had a large number of labor cases in his professional life and many times he had applied the forceps and endorsed Dr. Hundley's remarks thoroughly. Too often such interference is meddlesome.

*Dr. A. K. Bond* of Baltimore had delivered a woman in whom he had found a dense band of tissue across the cervix and when he examined it he found it was the result of suturing an old tear, the stitches having been put through the canal. He cut this fibrous, cicatricial band and the labor proceeded without complication. He related a case of old lacerated cervix where the tear was constantly suppurating, and at the birth of a child its eyes became infected with this matter. He asked what was the connection between a lacerated cervix and defective lactation.

*Dr. John Neff* of Baltimore related several cases of difficult labor in which he delivered, after great trouble, and in which a laceration healed without operation and one in which pregnancy followed.

*Dr. Woods* said that because a newborn infant had ophthalmia, it did not follow that the mother had had gonorrhea. It might be a non-specific ophthalmia, which usually gets well with little or no trouble. In the cases related by Dr. Bond, Dr. Woods thought that the child might have inherited syphilis or some post-partum affection not from the mother.

*Dr. Bond* said he had eliminated both of these sources.

*Dr. Morris* thought Dr. Bond's ideas were heretical. Some other trouble

must have affected the infant's eyes than the mother's lacerated cervix.

*Dr. A. K. Bond* then reported "An Epidemic of Typhoid among Children." The fever lasted longer in the younger children and the temperature was also higher. There was usually headache but no delirium worth mentioning. There were some nervous symptoms noticed in some of the patients; one was slightly deaf for a few days and several had nose-bleed. Rose spots were observed in all but three cases. There was no marked tympanites in any case and only slight iliac gurgling. The bowels were neither markedly loose or constipated and in only a few instances were the characteristic typhoid stools observed. The spleen was enlarged in one case and there was albuminuria for a few days. No casts were found. In all but two cases there was considerable catarrh of the lungs. In all these cases the tongue was coated, but the hard, dry character seen in adults was not observed here. There was not much emaciation. In one case there was gangrene of the mouth. The treatment was begun with thorough purging with castor oil and calomel. The sweet spirit of niter and sponging was used and in two cases baths and douches were tried, but they were given up later. The nourishment was looked after very carefully; a cupful of milk was given every two or three hours in the day and through the night, when necessary, and in some cases pepper-salt was also given. Small doses of Epsom salt, from a half drachm to a drachm, were given during the illness to keep the bowels clean. It is not easy to trace the cause of epidemics in a city. There were two buildings, both having the same water and milk supply, and nothing could be proved on either. The following conclusions were drawn from a study of these cases: 1. That children often bear high temperatures well in typhoid fever. 2. That bathing (in full bath) should be very judiciously applied, if at all. 3. That the disease in children under five years of age may easily be mistaken for other digestive disorders, or for bronchitis. 4. That albuminuria coming on during the fever does not

necessarily lessen the chances of a favorable issue. 5. That gangrene of the mouth, if superficial, may sometimes be cured by permanganate of potassium lotions. 6. That careful consideration should be given to the furtherance of digestion, as by the use of pepsin and acid; and also to the prevention of the accumulation of unwholesome or hardened feces in the intestines, as by the systematic and judicious employment of Epsom salt in the manner above indicated.

*Dr. J. W. Scott* of Belair asked why Dr. Bond preferred Epsom salt to calomel.

*Dr. W. Lee* referred to the atypical cases occurring in children and quoted the literature on that subject.

*Dr. Charles Bagley* of Bagley thought that the Epsom salt was an important part of this treatment. A too powerful purgative may cause hemorrhage and that should be considered before strong cathartics were given.

*Dr. James A. Steuart*, Secretary of the State Board of Health, said that it was difficult to trace these cases and the cause of the disease and it is hard to find the bacillus in water, but if the water contain sewage of course it is unfit to be used.

*Dr. Bond* said in reply to Dr. Scott that he gave Epsom salt because he did not wish to salivate with calomel and he thought the salt was a better purgative in these cases.

*Dr. Walter B. Platt* of Baltimore then made some remarks on "The Radical Cure of Inguinal Hernia in a Child by the Implantation of a Section of Aseptic Sponge to Occlude the Internal Ring." He also exhibited the patient. The boy came to him last August with an inguinal hernia like an old man's. He had used different kinds of trusses. The boy was seven years old. Dr. Platt tried the worsted truss, but with no results. He then decided to operate by a plan of which he had never heard though it might not be original. He opened the inguinal canal in the usual way, reduced the hernia and then he took a small piece of sponge, washed it thoroughly and by boiling he made it

thoroughly aseptic and put it in the conjoined ring and sewed it in there with the idea of keeping the hernia in place and having the sponge organized. It is not possible to speak of a cure, as it has been done only three months but so far the boy can run about and play and the hernia stays up and the sponge has caused no disturbance so it must be organized by this time. Macewen says that only about 40 per cent. of the cases operated on in the usual way are cured after two and a half years. If his case turns out well he shall treat all other children with the same kind of hernia in the same way. The idea is new to him and he hopes it will be successful.

*Dr. S. T. Earle* of Baltimore then read a paper entitled "A Critical Review of Modern Operations for Hemorrhoids." He briefly related the various methods of operation and then described the modification of Outerbridge's operation, which he preferred. He gave a demonstration of the clamp and manner of suturing and said it gave less discomfort than other operations.

*Dr. C. M. Ellis* of Elkton asked if Dr. Earle did a preliminary dilatation of the stricture before operation.

*Dr. Earle* said he rarely did this for no matter if dilatation was done there was a certain amount of burning of the rectum that demanded a hypodermic injection of morphia. In bad cases with many hemorrhoids he dilated first.

*Dr. C. H. Hollingsworth* of Belair presented "A Case for Diagnosis." The boy was seven years old and was taken sick about six months ago with a pleurisy on the left side followed by a pneumonia of that side and then that all cleared up and there was a pleurisy of the right side and that cleared up and the boy was going on well to recovery when he was suddenly taken with severe pains in the back of the neck and had a severe pain down the back and now his head is bowed forward and he cannot straighten it; he cannot put the feet to the ground; cannot use his hands very much and can lie in the same position but for a few moments only. His weight fell off at first but now he has regained about three pounds, due to the

tonic treatment, but he seems to be no better in other respects. There were hard nodules or lumps in the abdomen which seemed to disappear on purging. The sterno-clavicular and sterno-costal articulations are all enlarged and painful.

*Dr. W. F. A. Kemp* of Baltimore said it was not easy to express an opinion from a cursory examination but he was inclined to think it was tuberculosis, although the swollen articulations looked a little like a gouty diathesis. He suggested an examination of the urine microscopically and also of the sputum.

*Dr. W. W. Russell* of the Johns Hopkins Hospital then read a paper entitled "The Clinical Course of 47 Cases of Complete Extirpation of the Uterus for Carcinoma." He gave statistics on the results of the operation in these cases and explained the manner of operation and the danger of secondary deposits depending on the situation of the primary lesion. It may pass from the uterus to the bladder in front, to the rectum behind, or even to the vaginal mucous membrane, or to the ovaries, and he spoke of the results of early operations. In answer to Dr. Kemp he said that only one was living for five years after operation but that Boldt had reported a case that lived for 17 years after total extirpation of the uterus for carcinoma.

#### SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

ABSTRACT OF THE PROCEEDINGS OF THE EIGHTH ANNUAL MEETING, HELD IN WASHINGTON,  
D. C., NOVEMBER 12, 13 AND 14, 1895.

##### FIRST DAY, AFTERNOON SESSION.

*Dr. A. M. Cartledge* of Louisville, Ky., read a paper on "Hysterectomy in Acute Puerperal Sepsis with Report of Cases." The author reported two instructive cases, after which he summarized his conclusions as follows: 1. From our present knowledge of the causation and nature of puerperal infection, we may say it is largely a preventable disease. 2. When occurring, it is of the greatest importance to differentiate between puer-

peral intoxication or invasion of a piece of putrescent placenta or blood clot by saprophytic germs, and true septic infection or invasion of living cells by pathogenic bacteria. Puerperal sapremia, though in many cases producing the most alarming symptoms, is usually amenable to energetic treatment by curettage, antiseptic irrigation and satisfactory tubular drainage of the uterine cavity. 3. True septiæ infection should be treated by sterilizing the birth canal at the earliest possible time, free elimination by purgation and the prompt evacuation of superficial abscess accumulations about the cervix. Such a course may save the patient from more radical measures. 4. The differential points between puerperal intoxication and true puerperal infection are the comparative absence of pain, tympanites, and abdominal tenderness, and the more sudden onset and severe character of the symptoms in puerperal intoxication. Hysterectomy as a primary measure is never justifiable in septic intoxication, and when necessary it can only be after the mixed or secondary infection which may follow in the track of a primary sapremia. 5. Progressive involvement of the deeper structures, as evidenced by daily elevation of temperature, probably 103° F. in the evening and subnormal in the morning, together with night sweats, scanty secretions, ascending pulse, are indications for hysterectomy. 6. It is often impossible from the involvement primarily of the low pelvic structures to make a bimanual examination which will reveal the true condition of uterine appendages. But in view of the fact that these structures are not so prone to be invaded in the acute violent type of the disease, vaginal hysterectomy should be the operation of selection.

##### SECOND DAY, MORNING SESSION.

*Dr. Richard Douglas* of Nashville read a paper entitled "Splenectomy Statistically Considered, with Report of a Case." Gathered from all sources, the author finds on record 194 splenectomies. Of these, 126 were females, 57 males, and in 11 cases the sex is not given.

Furthermore, he finds that in 40 cases the operation was undertaken for wounds or injuries. Of this number 26 were males, and 14 females. If we deduct these, we find that the ratio of splenectomies for disease is 31 males to 112 females, showing the latter sex to be much more predisposed to disease of this organ. Dr. Douglas then reported the following case: Mrs. J. S., aged 33, housewife, multipara, native of Tennessee, family history good, has suffered occasionally with menorrhagia, but more recently from amenorrhea. She had malarial fever when twelve years of age. The last three years she has lived in the western portion of the State on the banks of the Mississippi and has suffered during this time from frequent attacks of intermittent malaria. About August 1 last, she suffered from an acute pain in the left side. A tumor was then discovered in that region about the size of a fist. Physical examination revealed a smooth, elastic, movable tumor, filling the left lateral region of the abdomen, its borders well defined, edges sharp and notched. It frequently changed its form; at times it appeared flat and smooth, again it would rise up as a sharp ridge extending from ribs to symphysis pubis. There was absolute dulness over the tumor. Vaginal examination revealed the uterus forward, the pelvis filled with a smooth, hard mass, which upon change of posture disappeared from the pelvis and occupied the left iliac fossa. She suffered with paroxysmal pain, not severe. A sense of weight, a dragging in the left side, flatulence, nausea and, occasionally, vomiting. There was some emaciation and slight anemia. There was no edema, ascites, vertigo, or insomnia. A blood examination of the case constituted a part of the report. A diagnosis of malignant hypertrophy of the spleen was made and, after due preparation, the abdomen was opened by a lateral incision at the outer border of the left rectus, the incision being about six inches long. The spleen was found displaced and free from adhesions. Its pedicle was secured by interlocking ligatures; pedicle was severed close to the organ. As additional

security against hemorrhage, ligatures en masse were employed; also individual deligation of splenic artery. After removal of the spleen bleeding from abdominal incision became very profuse and required several ligatures. Peritoneum closed by separate silk sutures, the abdominal wall coapted by usual interrupted silkworm gut sutures. The post-operative history of the case was a very stormy one, but one month after operation the patient is out of bed and now looks ruddy and well.

*Dr. W. E. B. Davis* of Birmingham contributed a paper entitled "Surgery of the Biliary Ducts." Dr. Davis reviewed the operative procedures practiced on the biliary passages and recommended for cases of obstruction from stone in the common and hepatic ducts that the obstruction should be removed and that no attempt be made to suture the incision in the duct or ducts. His experiments had demonstrated that the field of operation will be walled off and that no general inflammation will occur after this treatment. He had tested the value of gauze in draining bile in injuries of the gall bladder and ducts and reported cases where he had removed the gall bladder without tying the duct by packing with iodoform gauze. The animals got well. In other instances where he incised the gall bladder and ducts and packed with gauze around the openings, no stitches being used, the animals recovered. Complete walling-off of the general cavity was noted when the abdomen of the animal was reopened. The experiments of Dr. Davis demonstrate conclusively that the peritoneum is capable of taking care of a small amount of bile, but that large quantities or the constant extravasation of it will produce a fatal peritonitis usually in from twenty-four to forty-eight hours.

*Dr. John D. S. Davis* of Birmingham, Ala., read a paper entitled "Management of Cases which have Recovered from Appendiceal Abscess in which the Appendix was not Removed." The practice of dealing with appendiceal abscess by simply evacuating the pus and draining the cavity thoroughly without

any very extensive search, or the breaking up of adhesions in order to find the appendix, has been adopted by a large number of the leading operators for some time. More recently some of the leading surgeons have advocated, in all cases, that the operation should be made complete; that all adhesions should be freed and the appendix removed. One leading abdominal surgeon, who has perhaps done more work in pelvic surgery than any other man in this country, has advocated this plan of treatment in most vigorous terms. In a large proportion of cases of pus in the tubes and ovaries, gonorrhea has been an important factor in its production. Such pus is not septic and is not calculated to give rise to so dangerous a general inflammation as infection from an appendicitis or an appendiceal abscess. It is a notable fact that a ruptured tube or ovary will usually be followed by a circumscribed inflammation. It is the exception that a fatal general peritonitis results from such an accident. The most fatal forms of peritonitis are due to a ruptured appendiceal abscess. In fact, but few cases are saved when such an abscess ruptures into the general cavity. An operation on an appendiceal abscess is usually one of the simplest of procedures and is attended with almost no danger. Where the inflammation is circumscribed and the drainage is thorough, nearly all cases recover. The records of operations for appendiceal abscess show that the great majority of cases are cured after evacuation and complete drainage. Recurrence of the disease in such cases is rare. The appendix in a large proportion of cases having ruptured before the abscess formation, is completely drained through the abscess and permanently cured. In others the appendix is destroyed by the inflammation and there is nothing left of it when the abscess is operated upon. To make an extensive search for the appendix is liable to break up adhesions and then allow escape of septic fluid into the general cavity. Thus a very simple condition may be converted into one of the most serious that could happen to the peritoneal cavity. Dr. Davis believes

that there cannot be much need of breaking up adhesions, for they give way in a short time after the abscess is relieved. In breaking up these adhesions, in addition to the danger mentioned, the surgeon prepares a favorable condition for fresh adhesions, with the possibility of the bowel being fastened in a position that will produce pain and often obstruction. After the abscess is thoroughly cleaned out, gauze packed into the abscess cavity and between the abscess and abdominal wall will completely shut it off and the chances for recovery will be good in such cases. Dr. Davis does not favor the breaking up of adhesions and searching for the appendix in cases of appendiceal abscess.

#### SECOND DAY, AFTERNOON SESSION.

*Dr. John A. Wyeth* of New York City delivered a memorial address on "Dr. J. Marion Sims and His Work." Dr. Wyeth said it was safe to say that Marion Sims attained the highest position ever achieved in the history of the profession. He stands alone in this; his reputation as a surgeon was so world-wide that in any capital, in any country within the domain of civilization, he could command at any time a lucrative practice. Assuredly, there does not exist in the history of surgery another such distinction. In New York, London, Paris, Brussels, Berlin, Vienna, Rome, Madrid, Lisbon and St. Petersburg he found himself everywhere sought after, not only by the patients he could benefit, but by the leading members of his own profession, who were anxious to pay tribute to his wonderful genius. The study of his life should instill hope into the heart of every student. Born amid the most humble conditions in a backwoods county of South Carolina, he died the foremost surgeon of his country and of the world. What a transition from the log-cabin of the poor farmer in Lancaster District to the palace of St. Cloud, where he was a guest of Napoleon III, the trusted physician to the Empress, as he was to the highest and lowest of those who sought relief at his hands in any part of Europe. Toward the higher and purer civiliza-

tion, the progress of man is slow. As yet, the shadows of barbarism linger about him. His heroes are the destroyers, the Cesars and Napoleons, who covered the earth and buried beneath it countless lives, sacrificed upon the altar of personal ambition. But the time must come when those whose genius and works give life and health and happiness to the world will be first in the heart of man. In this purer temple of fame, along with those of Jenner, Ephraim McDowell, Morton, Lister, Pasteur and others, generations yet unborn shall read the name of Marion Sims. At the close of Dr. Wyeth's address, remarks were made by Drs. Robinson, Wilson, Nelson, Marcy, Engelmann, Kollock, Vander Veer, Gaston, Tiffany and Westmoreland, eulogizing Sims, most of whom were personally acquainted with him.

*Dr. George Ben Johnston* of Richmond, Va., read a paper entitled "Comparative Frequency of Stone in the Bladder in the White and Negro Races." It is commonly stated by writers on urinary diseases that stone in the bladder is of rare occurrence in the negro race. This is so at variance with his own experience that he has instituted an investigation either to prove the statement or to correct the fallacy. He selected the Southern States of Virginia, North Carolina, South Carolina, Alabama, Georgia, Tennessee, Kentucky, Florida, Louisiana, Mississippi, Arkansas and Texas as the field of inquiry. He selected four hundred representative practitioners to correspond with in order to procure the necessary data. He received three hundred and thirty-eight responses, ninety-four of which contained information, and the remainder were negative. He succeeded in collecting one thousand and sixty-eight cases of stone in the bladder. Of these, nine hundred and fifty-two were in white subjects, and one hundred and sixteen in negroes. It is at once observed that the negro cases represent 9.55 per cent. of all cases reported. This showing is quite sufficient to disprove the idea of immunity which the negro is supposed to enjoy.

Geographically these stones were dis-

tributed as follows: Alabama 10, Arkansas 11, Florida 28, Georgia 90, Kentucky 56, Louisiana 19, Mississippi 9, North Carolina 126, South Carolina 66, Tennessee 128, Texas 98, Virginia 430.

Sex is specified in 780 cases, and not stated in 280. Of those in which the sex is indicated, there were 691 in males, and 97 in females, or about seven times oftener in males than in females. There were 182 cases not subjected to operation and 584 in which stones were removed by the following methods: Lateral perineal, 249; median perineal, 100; suprapubic, 138; vaginal incision, 32; dilatation of female urethra, 28; crushing, 35 and operation not given, 5. Of those operated on, 541 recovered and 43 died. No report of operation in 304 cases. Dr. Johnston's own cases are incorporated in the foregoing statistics. During his twenty years' practice, he has made notes in 41 cases, which is the third largest list furnished by any reporter, and what seemed to him the enormous number of cases in the negro in the face of its supposed rarity caused him to set on foot the inquiries leading up to this paper. Of his 41 cases, there were 35 in whites, 6 in blacks, 39 in males and 2 in females. Thirty-nine were operated on, and two were refused operation on account of advanced kidney disease. Both died. In 25 cases, lateral perineal lithotomy was done, in 12 suprapubic, and in the cases of the two females the urethra was dilated and fragmentation practiced. He had no deaths following operation.

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**ASAFTIDA IN OBSTETRICS.**—Warman (*British Medical Journal*) finds that this drug is a most valuable therapeutic agent in midwifery. It is a direct sedative to the pregnant uterus and exercises no evil influence over the general system. It is of particular value when abortion is imminent, as it controls uterine irritability. On the other hand, it is of no use as a prophylactic agent in such cases and must not be relied upon when the abortion has proceeded so far as to require manual interference. In habitual constipation and in nervous conditions during pregnancy it is highly beneficial.

MARYLAND

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BALTIMORE, DECEMBER 7, 1895.

THE fact that milk is such an important food for infants and invalids makes it very necessary that it should be

*Milk Inspection.* as good and pure as possible and this is not a difficult

matter in the country, especially on farms where the milk is obtained from one cow or one herd of cows where there is no object in adulteration. In cities, however, the supply of milk and cream is usually through dairies, which collect the milk from many farms in the outlying districts, from which places it is sent on the railroad to the city consigned to the dairy wagons in the city for distribution.

The fact that milk is so often adulterated and diluted has led many cities to adopt and enforce certain laws against the sale or even the possession of milk below the standard and the penalties usually inflicted on the persons bringing such milk to the cities is confiscation of the milk or even a fine in addi-

tion. Now the supposition is that most dairy-men or milk dealers will cheat if they can find an opportunity, but to act on this idea in all cases is working a great hardship to the honest dealers.

To examine carefully a specimen of milk requires more skill and time than is usually possessed by the ordinary milk inspector. In Baltimore, for instance, the milk inspectors examine milk in all suspected cases, and are at the stations and large depots where the milk is gathered and have the right to test the milk at any stage, from its arrival in the city to its distribution. This examination is necessarily made hurriedly and by means of a lactometer or densi-lactometer. This of course gives only the specific gravity, which in normal cases should be between 1029 and 1034. If it is less than this dilution with water is suspected and the inspector has the right to pour it out into the street and the owner has no redress.

While this test has done much good in improving the quality of milk brought to the city and has been the means of detecting and punishing many dishonest dealers it has also done great wrong to honest men who suffered losses with the guilty. The lactometer test can detect the amount of solids in a liquid in proportion to the amount of that liquid, but it does little beyond that and little more can be learned of the character of milk short of a careful examination continuing over one or more days. Very rarely a low specific gravity in milk is due not to the addition of water, but to an excess of cream in very rich milk, so that this law, based on a hasty examination with a lactometer, prevents the importation of milk too rich in cream.

Any dealer who was dishonest enough before this law to bring into the city milk diluted with water knows enough to be aware of the fact that such milk may be brought up to the required standard by the addition of some substance. This law is good as far as it goes, but it is very faulty. It is stated that milk above 1033 is skimmed and below 1029 is watered. This is not true of rich milk containing an excess of cream. By skimming off the cream and adding water, milk may pass as standard.

While the milk inspection law has done and is doing great good, it should not work an injustice to the too honest dealers and in case of doubt the accused should be given a

hearing and his milk tested by more careful means before he is branded as a dishonest dealer.

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THE careful and comfortable transportation of the sick is a subject which has not received very wide attention.

**Transportation of the Sick.** At first ordinary wagons or carriages were used and later special vehicles with easy springs were adapted for the sick and wounded, but in spite of all these precautions, jolts and jars caused pain and added risk to the gravity of the disease or injury.

Ambulances are now used in all modern progressive cities, but in very few cases have they been fitted with the rubber and pneumatic tire. It seems strange that while pleasure vehicles, such as bicycles, carriages and racing carts, have used the rubber tire, it has been so little employed where jars and jolts are not only disagreeable, but even dangerous.

Anyone who has used a wheel knows how gently a well filled tire can run over even a rough road. How strange then that all ambulances are not fitted with heavy pneumatic tires, so that the sick may be transported as easily and as comfortably as possible. At the present time the ambulance makes all possible haste, but little care is taken to protect against jolting.

The modern hospital is so thoroughly equipped, that even the most luxurious with every comfort of home feels safer in such a hospital. Some architects advocate, in their plans of a large dwelling house, a room set apart which may be used for the sick. This may be necessary in a large country house, but in the city no room can equal a private room in a good hospital where physician and nurse are always within call and where every attention may be procured and the skilled hand is always ready to give help. To remove the sick to such institutions, an ideal ambulance should have firm and well filled pneumatic tires, and then the dangers of removal when the disease is well advanced or when the injury is not a recent one will be reduced to a minimum and the results will be much more favorable.

The bicycle itself is now used very extensively in military manoeuvres and soldiers are instructed how to transport on a bicycle the wounded from the battlefield. Pneuma-

tic tires may be more expensive and less durable than the kind now in use on ambulances, but the difference in expense is compensated for by the saving of suffering and pain.

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THE bicycle is not only a luxury, in many cases it is a necessity. Bicycling, however,

is still ranked as a form of *The Bicycle and the Prostate.* athletic exercise and as such it should be followed with a certain amount of caution by those who use it too much.

Dr. T. A. McLaughlin of Washington reports cases in the *Virginia Medical Monthly* showing that cycling may cause prostatic disease principally on account of a badly made saddle, and especially when the rider assumes an improper position, and in addition to that is in a relaxed physical condition.

The principal danger, the writer thinks, is from badly fitting saddles. They should be wider, offering more support for the tuberosities of the ischium, and the peak in front should be much shorter with a properly fitting saddle, thus dangers of prostate disease will be very little.

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IN spite of attempts to check the spread of infectious and contagious diseases, and of the fact that some progress

**Restriction of Disease.** in this direction has been made, outbreaks of disease dangerous in themselves and their complications still continue to occur in civilized communities. Typhoid fever has been appearing to no small extent in many regions, and measles has spread to an alarming degree in the large cities. The latter disease may seem rather harmless, but the complications and results are too often grave. It is a fact that this disease is spread very effectually by the schools, because there is no adequate means of inspection and because it seems almost impossible to trace the disease to families where members are careless or criminal, in neglecting to keep the well children of the family away from the sick and away from school. Watchfulness on the part of parents, guardians, teachers and officers will reduce the morbidity and mortality from many preventable diseases. It would be too ideal to expect the contagious disease to be stamped out entirely, but that should not curb the zeal of sanitarians.

**MEDICAL ITEMS.**

We are indebted to the Health Department, of Baltimore for the following statement of cases and deaths reported for the week ending November 30, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		16
Phthisis Pulmonalis.....		22
Measles.....	232	2
Whooping Cough.....	5	
Pseudo-membranous Croup and Diphtheria. } Mumps.....	31	13
Scarlet fever.....	5	
Varioloid.....	22	1
Varicella.....	7	
Typhoid fever.....	13	7

Horseless carriages are used by the country physicians in France.

Dr. George J. Engelmann has moved from St. Louis to No. 336 Beacon Street, Boston.

Health Commissioner McShane wants more power to inspect dairies supplying Baltimore with milk.

Professor Riedel of Jena has been called to the Chair of Surgery at Göttingen in succession to Professor König.

The Nurses' Association will have a course of post-graduate lectures from well known physicians of Baltimore.

Dr. David D. Stewart has been elected Professor of Diseases of the Stomach and Intestines in the Philadelphia Polyclinic.

Dr. Wm. H. Welch of the Johns Hopkins University has been elected President of the Association of American Physicians and Surgeons.

Professor König of Göttingen has been selected as the successor of the late Professor Bardeleben in the Chair of Surgery in the University of Berlin.

Dr. John S. Billings, retired, has been presented with a purse of \$10,000 by physicians in recognition of his valuable services in issuing the Index-Catalogue.

No person authorized to practice physics or surgery, it has been enacted in Pennsylvania,

shall be allowed, in any civil case, to disclose any information which he acquired in attending the patient, in a professional capacity, and which was necessary to enable him to act in that capacity, which shall tend to blacken the character of the patient, without his consent.

About January 1, 1896, *The Journal of Experimental Medicine*, a quarterly, will be issued under the auspices of the Johns Hopkins University, with Dr. William H. Welch as editor. This new medical journal, which will probably be published by the Appletons of New York, will be the only one of its kind in this country and will be modeled after similar works in Europe. There will be no editorial page and the whole number will be devoted to articles of original work. Although the arrangements are not yet completed, Dr. Welch will probably be assisted by Drs. H. P. Bowditch of Harvard, S. H. Chittenden of Yale and W. H. Howell of the Johns Hopkins, in the Department of Physiology; Drs. J. J. Abel of the Johns Hopkins, Arthur R. Cushny of Ann Arbor and H. C. Wood of the University of Pennsylvania, in the Department of Pharmacology; Drs. J. G. Adami of Montreal University, W. T. Councilman of Harvard and T. M. Prudden of Columbia, in the Department of Pathology; Drs. Reginald H. Fitz of Harvard, William Osler of the Johns Hopkins and William Pepper of the University of Pennsylvania, in the Department of Medicine. In addition to these there will be a large corps of collaborators, among whom are Drs. A. C. Abbott, J. S. Billings, Francis Delafield, H. H. Donaldson, George Dock, L. Hektoen, Surgeon-General Sternberg, E. L. Trudeau, E. T. Reichert, G. F. H. Nuttall, S. Weir Mitchell, W. T. Howard, Jr., W. Gilman Thompson, I. T. Van Gieson, S. J. Melzer, Graham Lusk, Herman Biggs, Meade Bolton, John Guitéras, H. A. Hare and Theobald Smith. The departments to be covered include physiology, bacteriology, pharmacology, physiological chemistry, hygiene and practical medicine. The four numbers will make a volume of 600 to 700 pages, which will be illustrated with plates and diagrams. The price will be five dollars a year. Business communications may be addressed to Messrs. D. Appleton & Co., New York, or Mr. N. Murray, Johns Hopkins University. The editorial address is 935 St. Paul Street, Baltimore.

## WASHINGTON NOTES.

The regular meeting of the Medical Society was held on Wednesday evening, November 27, the President, Dr. Samuel C. Busey, in the chair. Dr. I. S. Stone, who had been so ill for a long time, presented a case and the specimen of the result of Appendicitis. Dr. J. Wesley Bovée presented two cases of Hysterectomy for Immense Fibroids, with Specimens. They were discussed by Dr. Joseph Taber Johnson. Dr. A. Jacobi of New York was the invited guest of the Society. He read a paper on "Nephritis in the Newly Born." He was thanked by the whole Society for his excellent paper. The President then appointed a Committee, consisting of Drs. C. H. A. Kleinschmidt, T. C. Smith and G. L. Magruder, to draw up resolutions on the death of one of its members, Dr. E. C. Merriam. Dr. Ephraim C. Merriam died at his home on New Jersey Avenue of pralysis, at the age of fifty-seven. He was a graduate in Medicine of Dartmouth College in 1863. He became a medical cadet in the United States Army and was afterwards made Assistant Surgeon. Toward the close of the war, he was transferred to Washington, becoming Assistant Surgeon to the Army Hospital.

Dr. Walter R. Beatty of this city has been appointed Agency Physician to the White Earth Indian Reservation, in Minnesota. Dr. Beatty is a very competent young physician, being a graduate of Columbian University and for some time an interne at the Emergency Hospital. He was also Resident Physician of the Astoria General Hospital of New York.

Dr. F. A. Nazzine has been appointed Physician to the Poor, vice Dr. S. L. Hannon.

Dr. W. C. Woodward, the Health Officer, has planned for a \$49,000 Isolation Hospital for Contagious Diseases, \$12,000 for a new morgue and a sufficient appropriation for a disinfecting plant near the smallpox hospital. It is said that the Commissioners in their report to Congress will recommend the appointment of a Chief Inspector of the Health Department, at a salary of \$1300 a year, to act as Deputy Health Officer.

A special meeting of the Medical Association of the District of Columbia was held Saturday, November 30, 1895. The object of this meeting was to consider the proposition to establish in Washington a Department of

Public Health, the head of which should be an additional Cabinet officer. The President favored such a measure in his message to the Fifty-second Congress and Senator Gray had a bill for its establishment. A committee, consisting of Drs. H. L. E. Johnson, Samuel C. Busey, W. W. Johnston, J. R. Wellington and C. H. A. Kleinschmidt, was appointed to coöperate with other associations in urging the passage of such a law by the present Congress. Dr. Jerome Cochran is Chairman of the Committee on this project, appointed by the American Medical Association.

## PUBLIC SERVICE.

OFFICIAL LIST OF CHANGES IN THE STATIONS  
AND DUTIES OF MEDICAL OFFICERS.

## UNITED STATES ARMY.

*Week ending December 2, 1895.*

The leave of absence granted First Lieutenant John S. Kulp, Assistant Surgeon, is hereby extended one month.

Leave of absence for one month, to take effect about December 4, 1895, is hereby granted Major George W. Adair, Surgeon, Washington Barracks, D. C.

## UNITED STATES NAVY.

*For One Week ending November 30, 1895.*

Surgeon F. Anderson detached from the "Amphitrite" and ordered to the "Dolphin." Surgeon P. M. Rixey detached from the "Dolphin" and placed on waiting orders.

Surgeon J. E. Gardner detached from Port Royal Station and ordered to the "Amphitrite."

Passed Assistant Surgeon I. W. Kite detached from the "Franklin" and ordered to the Naval Hospital, New York.

Passed Assistant Surgeon T. A. Berryhill detached from the Naval Hospital, New York, and ordered to the Port Royal Naval Station.

## BOOK REVIEWS.

HAND-BOOK OF THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES. By Arthur Van Harlingen, M. D., Professor of Diseases of the Skin in the Philadelphia Polyclinic, etc. Third Edition. Philadelphia: P. Blakiston, Son & Co. 1895.

This book is almost double the size of the previous edition. There are many new illustrations and a chromo-lithograph. Many chapters, as that on tuberculosis of the skin, have been entirely rewritten. New formulas have been substituted for old ones. This book will still remain a great favorite with the student.

**CURRENT EDITORIAL COMMENT.****PHYSICIANS' WEALTH A MYTH.***The Atlantic Medical Weekly.*

To THE popular mind all physicians are or should be wealthy. The practice of medicine appears to be one of the easiest methods of accumulating riches, yet to those of us who are within this charmed circle, the circle in our case being composed of unpaid accounts with a fringe of expenses which goes clear around it, the difficulty of becoming wealthy is very apparent.

**THE DISPENSARY EVIL.***Dominion Medical Monthly.*

WE can see no reason why a doctor should be expected to give his time and services to the public any more than a lawyer or a member of any other profession. The clergyman receives a stated salary and is not dependent on his own exertions for a livelihood and has regular hours, but the physician must be at the beck and call of every charitable institution in the city. In theory, his time is devoted to the practice of medicine, by which he earns a livelihood; in fact, every spare minute is devoted to giving his services free and doing everything he can to injure his own and his brother practitioner's finances. In no other walk of life, in no other profession, does such a ridiculous state of things exist.

**PROGRESS IN INSTRUCTION.***Mathews' Medical Quarterly.*

THE two leading questions in medical education are practical instruction in classes in properly equipped laboratories and abundant clinical material and bedside instruction. The medical school that does not magnify this method of instruction will sink into well-deserved obscurity. There is no excuse for any graduate to say, as nearly all of his predecessors were forced to do, that he has no practical knowledge of the microscope, stethoscope, laryngoscope, or that he has not had ample opportunities for witnessing all the important operations in surgery according to modern methods and has personally examined and prescribed for patients in the clinics and at the bedside. The profession has taken the lead and the community will speedily follow and require more knowledge and higher skill of students having such advantages.

**PUBLISHERS' DEPARTMENT.**

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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209 Park Avenue, Baltimore, Md.

**NOTES.**

NEVER prescribe alcohol in chronic disease.  
\*

SUBNITRATE of bismuth decreases all the secretions.  
\*

PUS-PRODUCING diseases yield readily to calcium iodide.  
\*

IN rigid os, a little lobelia given once or twice will relax it nicely.  
\*

CHROMIC acid, twenty per cent. solution, is a good application to warts.  
\*

IN uterine relaxation with prolapsus, give Aletris Cordial a faithful trial.  
\*

FLUID extract of eucalyptus, in five drop doses, will relieve distressing cough.  
\*

CLEANLINESS should be the first consideration in the treatment of gonorrhœa.  
\*

FOR a bad cold, try strychnine arsenite, one one-hundredth grain every two hours.  
\*

EARLY applications of strong solutions of nitrate of silver are recommended for bed sores.  
\*

THERE is no antagonist to chloroform so valuable as strychnine given in full doses, and on the slightest sign of cardiac or respiratory failure.  
\*

CHRONIC nasal catarrh, when there is a dripping back into the throat, finds a ready cure in hydrastis, triturated with one per cent. sugar of milk, four doses a day.

# MARYLAND MEDICAL JOURNAL

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## ORIGINAL ARTICLES.

### CIRCUMCISION.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
NOVEMBER 5, 1895.

By *T. Ritchie Stone, M. D.,*  
Washington, D. C.

Of all the minor operations in the realm of surgery, that one which deserves, from its oftentimes absolute necessity, care and attention, the operation of circumcision is looked upon as so simple that it is hardly worthy of dexterity or thought. That the "redundancy of prepuce" plays an important part in the economy of the patient is fully shown in his reluctance to part with it. This operation, with its undoubted good results, is now occupying the attention of many specialists. Arguments are being arranged on both sides and the time is not far distant, I hope, when the great importance of this simple relief will be recognized.

Jonathan Hutchinson, Surgeon to the Metropolitan Free Hospital, in the *Medical Times and Gazette*, London, 1855, writing on the "Influence of Circumcision in Preventing Syphilis," says that the Metropolitan Free Hospital, situated in a locality in which many Jews reside, its out-patient's rooms furnish a good field for estimating the relative prevalence of different diseases amongst them and others. His Jew patients have, he believes, been in proportion of nearly one-third to the others. The subjoined table shows the proportion of the two classes of venereal disease :

Total of Venereal Cases, not Jews,

272; Gonorrhœa, 107; Syphilis, 165; Proportion of Gonorrhœa to Syphilis, 0.6 to 1.

Total of Venereal Cases, Jews, 58; Gonorrhœa, 47; Syphilis, 11; Proportion of Gonorrhœa to Syphilis, 4.3 to 1.

The cases of syphilis presented by Jews are only as 1 to 15. That this difference is not to be accounted for, either by superior chastity or their unwillingness to seek medical aid for such diseases, is conclusively proved by the fact that they furnished very nearly half the cases of gonorrhœa. The circumcised Jew is then very much less liable to contract syphilis than an uncircumcised person. No one who is acquainted with the effects of circumcision in rendering the delicate mucous membrane of the glans hard and skin-like will be at a loss for the explanation of the circumstance. During this period, he had 252 children under five years of age under his care. Of these, 179 have been of Christian parentage and 73 of Jewish. Among the former have occurred 27 cases of congenital syphilis, while among the latter there have been but 3. Of a total of 97 women who have during the year come under treatment for one or the other of venereal disease, 92 have been Christians and 5 Jews. Of the 91 of the former no fewer than 61 have suffered from syphi-

lis and at least two-thirds of these were married women, who there was every reason to believe had contracted the disease from their husbands without any fault of their own. Hutchinson thinks it the duty of the surgeon invariably to remove the prepuce of infants born with congenital phimosis.

In the Clinical Lectures and Reports, London Hospital, 1865, 58, 64, Mr. N. Heckford, M. R. C. S., Late House Surgeon to the Hospital, in writing on "Circumcision as a Remedial Measure in certain cases of Epilepsy, Chorea, etc.," gives a history of five cases of children aged 8, 13, 12 years and 6 months, 6 years and 6 months and 6 years respectively, who had elongated prepuces, masturbated and suffered from epilepsy and chorea. They were all circumcised. Case 1, cured of chorea and is able to walk. Case 2, epileptic, was free for two months, and also improved in other respects. He subsequently returned suffering as before. Under treatment, the paroxysms were lessened in severity, but they never entirely ceased for more than a few days at a time. Case 3. Has marked twitchings of facial muscles, accompanied by partial loss of consciousness. At other times quite idiotic. For some time after operation, both during his stay in the hospital and at home, his improvement, both mentally and physically, was marked; but as in the preceding case he eventually presented himself again nearly as bad as ever. Case 4. - Epileptic for three years. Four weeks after, "the boy is much stronger and better in himself, and I can now trust him alone in the street. His talk is much more sensible, and he does not behave so foolishly as before. The fits are not near so strong, and they do not happen so often; he has lately gone a month without having one. He still plays with himself (masturbates). This boy also suffered from ascarides." Case 5. Aged 6, had epilepsy since his 18th month. During the stay in hospital (after operation) he remained quite free from any attack, and improved in all other respects. He says "Granted then that masturbation does cause or aggra-

vate cases of brain disease, the question arises as to what effect circumcision has in the prevention of the practice?" I would answer that in the young subject its efficacy lies, first, in breaking the chain of habit; and secondly (especially in those children who suffer from phimosis), by preventing the retention of irritating secretions, it removes what is probably the main source of starting point of the evil.

In the *Western Journal of Medicine*, Volume 4, 1869, Dr. James Thompson, late Surgeon Fourth U. S. Light Artillery, in a paper on Circumcision says that: In a period of less than one year he performed circumcision upwards of 200 times, some for chancres in the prepuce, others for chancres on the glans, some for gonorrhœa, gleet, etc. All recovered in a period averaging about four weeks, excepting one, who was attacked on the sixth day after the operation with erysipelas of an adynamic type and died on the twelfth day from date of operation. Most of the operations were performed upon colored men, 70 per cent. of whom have remarkably long foreskins, which almost invariably cover their glans. Several of the cases, however, occurred amongst the white men, one of whom presented himself to me with a gleet of nine months' duration, which was rebellious to all medical treatment, local or constitutional. He was circumcised and his gleet was arrested as if by magic. He had several cases in his private practice cured by circumcision when all other means had failed. He also cured two cases of spermatorrhea within the last year by circumcision, when other treatment had failed. Both had long prepuces. Again in his article he says, "It is further my opinion that every person whose foreskin covers the glans ought by all means to be circumcised; then there would be less liability of his contracting the various venereal diseases, or herpes preputialis."

He says, "We should consider the effect which a nozzle-ended penis has on the minds of some persons; some are ashamed to be seen bathing by their fellow man, or to be examined for the

army or for life insurance, and no doubt, in many instances, to contract matrimonial alliances. In such cases, circumcision is one of the greatest boons that can be practiced on suffering humanity, and should be urged upon the people. It is further my opinion that in the diseases above mentioned, circumcision is beneficial in cases even where the patients have not a redundancy of tissue forming the prepuce I have never seen one who could not spare a small annular slice, in order to the cure of such a troublesome and rebellious disease."

In the Transactions of the American Medical Association, Vol. 21, 1870, Dr. Lewis A. Sayre, in a paper entitled "Partial Paralysis from Reflex Irritation, caused by Congenital Phimosis and Adherent Prepuce," cites three cases cured by circumcision, as follows: "Boy 5 years of age, unable to walk without assistance or stand erect, his knees being flexed at about an angle of 45°, and Dr. J. Marion Sims had sent for him to perform tenotomy upon his hamstring tendons. In two weeks after circumcision he was able to walk alone with limbs quite straight. In six weeks he had entirely recovered. No other treatment was used." Case 2. Lad of 14 years whom he had treated for paralysis of his legs without effect. The father called on him when the above boy made his farewell visit, so it occurred that the paralysis was possibly due to the same cause. Examined penis, found prepuce terminating in an opening scarcely large enough to admit a small probe. Operated March 23, 1870. On April 27, walked more than a mile without fatigue and shows no signs of paralysis whatever. June 15, 1870, the boy has gained nine pounds in weight since March 23, is robust and ruddy-cheeked, and has no symptoms of paralysis whatever. Case 3. Boy, aged 15; a slender, pale-faced, ghostly-looking boy, was sent to him for "nervousness and fainting fits." Boy said "his legs would not hold him up" and had "falling fits." He had a redundant prepuce, which terminated in a rigid inelastic ring-like orifice, scarcely large enough to admit an ordinary knitting needle. The slightest ir-

ritation of extremity of penis produced most painful erections. He was troubled every night with painful erections and frequent emissions. An operation was done; six weeks after the operation he has not had a single fit, although he used to have one or two almost daily. He had but two nocturnal emissions and has increased in flesh and strength. On April 7, 1870, three cases of hip disease in the second stage came to him within a few minutes of each other, aged 7, 9 and 13 respectively; the latter had a long, worm-like projecting prepuce with an exceedingly small orifice, which admitted a small probe for nearly one-half inch before the glans was reached. The boy was clumsy on his legs and fell frequently. The other boys had adherent prepuces, which were torn from the glands. They were clumsy in walking and fell frequently. Dr. Sayre says, "The question now came in my mind, could these numerous slight falls have been the cause of the local disease in the hip-joint?" Again, "I am quite satisfied from recent experience that many of the cases of irritable children, with restless sleep and bad digestion, which is often attributed to worms, is solely due to the irritation of the nervous system, caused by an adherent or constricted prepuce. Hernia and inflammation of the bladder can also be produced by the severe straining necessary to pass the water in some of these cases of contracted prepuce."

Dr. M. J. Moses (*New York Medical Journal*, 1871), in asking what is the value of the operation, without reference to special lesions, says that masturbation is one of the effects of a long prepuce, which is contracted and irritated. A removal of this appendage exposes a cold blue, congested glans, behind the corona of which, firmly packed, is a ridge of fetid sebaceous matter. As regards cleanliness, he says even in the most normally-formed prepuce, attention to this condition, to say the least, is more apt to be neglected than when, after the carefully performed operation of circumcision, the glans is easily reached and the secretions removed. Is the operation a painful one?

He says, "If the operation is well and skilfully done, it is one involving but slight suffering, as can be attested by the fact that I have operated upon sleeping children, who only awakened at the first incision, relapsing into a tranquil slumber during the completion of the operation. What is statistical proportion of accidents? He refers to the records of the late Dr. Abrahams, who probably did the operation oftener than anyone of his time, and who on his visit to the Holy Land deposited several thousand foreskins in the shrines of Jerusalem. He never heard of a death among his cases. What is the cause of the accidents? He says hemorrhage and tetanus; the latter is very rare and very fatal. The occurrence of hemorrhage is much more frequent and happens oftener as the result of neglect than mere accident. Though accident may complicate any operation, even when every precaution has been taken to guard against misfortune, yet, of course, the occurrence is much more liable to happen when no care has been taken, than when every avenue to danger has been guarded. Circumcision is an operation of the simplest nature, and the mutilations we often see are no more necessary than is amputation of the forearm, for the cure of a diseased finger nail.

The object of the ceremony, as ordered in the Mosaic Code, is to liberate the glans from its close mucous covering, by dividing the muco-dermoid fold, near its point of juncture. To do this, the sacrifice of some little tissue is necessary, but so little, in fact, as to be scarcely appreciable. He claims that the operation as performed by rabbinical appointees frequently involves the loss of too much tissue, often thus compromising considerably large vessels, which frequently accounts for secondary hemorrhage. The operation should be done by a surgeon and the condition of the child, as to his ability to undergo the ordeal, submitted to his direction. What special diseased conditions are frequently due to a neglect of the ordinance? Phimosis and paraphimosis. Balanitis and herpes. Venereal contact is ten

times more liable to inoculate the unfortunate possessor of this appendage, and in cases of this kind, especially where the ulcer appears near or on that portion of the prepuce attached to the frenum, permanent contraction of the preputial opening results, retarding treatment, and ultimately rendering operation absolutely necessary.

Retention of urine from spasmodic stricture is frequently the penalty of possessing a prepuce and I have seen many cases where I could not trace a permanent stricture of the urethra behind the fossa navicularis to any cause, but the constant pressure of the prepuce upon the glans, bending the urethra back upon itself at the point named. Nocturnal pollutions and resulting spermatorrhea are frequently superinduced from an irritating pressure upon the glans. In 1868 he operated upon twelve or thirteen cases in adults, liberating in some instances incarcerated glans, and relieving nervous irritability, amounting to absolute mania. He gives the following citable case, a child about two months old, whose foreskin was short and tightly constricted, pressing the penis almost back to the pubes. He circumcised the child. The preputial opening was puffy and irritated and not in a direct line with the meatus. The child would start in his sleep a great many times and awaken with a scream, insensibility attended by clonic spasm. Urine has not been passed for twenty-four hours. Warm fomentations and baths succeeded in inducing the flow of urine, and the child recovered, but was left with an acute hyperesthesia of the whole body and a spasmodic contraction of one of his legs. This was all relieved by the operation.

Dr. W. H. Winslow reports in the *Philadelphia Medical Times*, 1873, Vol. III, p. 786, two cases of circumcision. Case 1. Congenital phimosis. Prepuce inflamed and discharging. Recovery rapid and satisfactory. Man aged 27. Case 2. Young man aged 23. Gonorrhea with congenital phimosis. Treated unsuccessfully by several physicians, though he had taken medicines ad nauseam. Had also spinal irritation;

operated upon. Married eight weeks after.

Dr. H. G. Howse in a "Note on the Operation of Circumcision in the Adult" in Guy's Hospital Reports, London, 1873, third series, Vol. 18, proposes, after removing the skin in the ordinary way, to cut out the wedge-shaped piece of mucous membrane at the frenum with a pair of scissors and then snip the frenum clearly away from the glans, thus removing it and the wedge-shaped bit of mucous membrane in one piece together. He says: "The frenum may be looked upon as a mere fetal remnant, having no very definite function. On the other hand, its presence is sometimes decidedly prejudicial." Two or three such cases have fallen under his own observation, where it was absolutely necessary to divide it in the adult, so much inconvenience did it cause from its tight fibrinous condition. In these cases it had acted as a band, causing the organ to become curved when distended with blood, behaving in fact very much as in the condition of hypospadias, where the corpus spongiosum is congenitally deficient. This is a very important thing in our hospital patients, where a ruptured frenum often gives rise to the formation of sores in that region, hence it is that in such patients we so often see chancres about this portion of the corona.

Local Surgeon Major F. P. Staples, A. M., M. D., in an article in the *Indian Annals of Medical Science*, 1875, Vol. 17, on "Circumcision," reports four cases. Case 1. Congenital phimosis with syphilis, large induration beneath the prepuce. Case 2. Phimosis due to syphilitic inflammation. Case 3. Congenital phimosis with syphilis, hard induration beneath the prepuce. Case 4. Congenital phimosis with balanitis.

Otis of New York, in the *Medical Gazette*, 1880, Volume 7, says: "A common difficulty that I find as a result of this redundant prepuce is sexual weakness. I find cases troubled with frequent seminal emissions, with imperfect erections and general weakness of the sexual apparatus most commonly associated with elongated prepuce. The

parts are kept in a sodden condition and a certain amount of heat is generated through the constant poulticing of the glans penis by the redundant prepuce. I am satisfied that there is a loss of nerve power in such cases, through the chronic engorgement and hyperesthesia which results. The redundant prepuce not unfrequently sets up an irritation which is transferred to the seminal apparatus, inducing involuntary emissions, premature ejaculations and mental depression. Especially are such troubles likely to be aggravated, if not produced when the prepucial orifice is contracted. This condition, which we call phimosis, renders cleanliness difficult and the sebaceous secretions of the part accumulating furnish an added source of irritation and an unanswerable argument in favor of circumcision.

Dr. B. M. Rickets, in a paper on "Circumcision from a Dermatological Standpoint," in the Cincinnati *Lancet-Clinic*, 1888, N. S., Vol. 20, pp. 40-43, says: "Operated on two cases. One for papular eczema of the prepuce and one for chancroid." He advises circumcision as follows: Incipient malignant growths, common warts, vegetation, cicatrices from burns, true or false chancres, ulcers or congenital malformations, all demand prompt surgical interference. We have all, no doubt, seen the good results following circumcision in children suffering from cerebral irritation, hystero-epilepsy, chronic convulsions, and those on the verge of idiocy. Just what role the presence of an elongated prepuce plays in cerebral disturbances is yet uncertain, yet we feel assured that good results follow the operation.

In the *Medical Standard*, Chicago, 1889, Vol. 6, pp. 138-139, Dr. A. U. Williams reports that he has made 400 circumcisions and fully 50 per cent. were for the cure of herpes. Many men who have herpes imagine they have syphilis and with or without the advice of a physician take constitutional treatment. Many come to Hot Springs thinking they have "blood disease." It is for this reason and for cleanliness that I advocate circumcision. I would follow in the footsteps of Moses and cir-

cumcise all male children. The operation is simple and free from danger.

In the *Annals of Gynecology and Pediatrics*, Dr. J. Henry C. Sims sums up as follows: That the operation is one which may be performed for moral reasons; one which is demanded for hygienic purposes; one which is frequently necessary for pathological conditions; and finally one which is of unquestionable importance.

In the *New York Medical Journal*, Dr. J. C. Crossland says that anatomists and lexicographers assign no function to the foreskin other than that of a covering for the glans. Suppose that to be its real and only function. It then becomes necessary to determine whether that function is essential or conducive to the organic and functional integrity of the genitalia. A consideration of the conditions which ensue upon the removal of the foreskin will determine this matter. In consequence of circumcision the epithelial covering of the glans becomes dry, hard, less liable to excoriation and inflammation and less pervious to venereal viruses. The sensibility of the glans is diminished, but not sufficiently to interfere with the copulative function of the organ or to constitute an objection. The activity of the odoriferous glands of Tyson situated on the corona and cervix is diminished, a desideratum indeed. The changed condition of the epithelium is a sufficient substitute for the prepuce as a protection. Therefore, without fear of contradiction, he concludes that the foreskin is non-essential.

In the Cincinnati *Lancet-Clinic*, Dr. B. M. Rickets gives indication for operations as follows:

Local indications: Hygienic, phimosis, peraphimosis, redundancy (where the phallus more than covers the glans), adhesions, papillomata, eczema (acute and chronic), edema, chancre, chancroid, cicatrices, inflammatory thickening, elephantiasis, nevus, epithelioma, gangrene, tuberculosis, preputial calculi, *a*, hip-joint disease, *b*, hernia.

Systemic indications: Onanism, seminal emissions, enuresis, dysuria, retention, general nervousness, impotence, convulsions, hystero-epilepsy.

He says that he makes it a rule to remove the prepuce in every case of gonorrhea he treats. If this is done no complication with the phallus will arise. Cleanliness can better be secured and more perfect drainage obtained, which surely lessens the possibility of cystitis and orchitis. He uses catgut sutures. Dressing generally dry one and allows it to remain a week. A wet dressing is apt to cause an erection. He says he feels confident in stating that there are not enough of these operations performed. In closing the discussion he says, "The observations of Dr. B. have been that longevity of the Jews is 45 per cent.; that of the Christians is 36 per cent. There must be something in the operation. There is 17 per cent. less consumption in New York among the Jews than among the Christians. I have made a careful study for the last eight or ten years and am free to confess that I am of the opinion that all males should be circumcised as soon after birth as is practicable. The Jews, whose custom it is to have the operation made, have a less mortality, fewer still-born, less illegitimacy, less crime, less insanity and greater longevity than the Christians."

In the Proceedings of the Florida Medical Association Dr. Angus A. Gillis says, "In the first place I wish to point out the important role that this operation plays in the curative treatment of a class of nervous diseases that follow as sequelae to local affections, the primary cause of which is subpreputial irritation, chancre, chancroid, adhesion of prepuce to glans, presence of calculi underneath the foreskin, etc. Secondly, to raise a voice against the idea that some surgeons have that every prepuce that covers the glans should be cut off without respect to the conditions present that may demand its removal, or enter a plea for its natural position."

Clifford of London says, "It is well known that a long prepuce is a cause of trouble, and is a frequent source of disease, often requiring its removal in after-life. 1. In infancy it causes constitutional as well as local irritation, and

many a child at one time puny and sickly has quickly thriven and become robust when the foreskin has been removed. 2. In boys the natural secretions of the part smegma, etc., are liable to accumulate between the prepuce and glans penis, and balanitis is frequently met with as a result. 3. If a sore occurs underneath the foreskin, phimosis is a common consequence, often necessitating circumcision before proper treatment can be undertaken. Phimosis is also met with as a congenital condition. Such a condition favors the retention of the secretions of the part and leads to one or other of the diseases here mentioned. 4. A long foreskin is a mechanical impediment to the passage of urine and sometimes gives rise to symptoms resembling those of stone in the bladder. 5. It is a frequent cause of incontinence of urine at night. 6. The straining to pass water, which its presence occasions, is one of the recognized causes of hernia, and it has been known to be a cause of prolapse of the rectum. 7. Paraphimosis is another condition brought about by a long and tight prepuce. 8. The prepuce tends to keep the surface of the glans penis moist and wet, and unknown to the individual, little cracks or fissures are liable to occur on and around it. These may be easily inoculated by any noxious or contagious matter to which they may be exposed. Hence they are often the starting point of chancre or syphilis in young persons, and of chancre in the aged. 9. Circumcision has been performed and found beneficial in some constitutional diseases. It has been advocated in hysteria, epilepsy, chorea, etc., and cases are mentioned in medical literature where patients suffering from these and other diseases have been benefited and in some cases cured by it. 10. Circumcision is conducive to cleanliness, etc. But even in our temperate climate, if circumcision became a more general practice, distinct advantages would be found to follow. Hardly a week passes without the operation being performed in our hospitals for the relief of disease, which would never have had an existence if the prepuce

had been removed in infancy. The tendency of modern medical science is not only to cure disease when it is already present, but also to prevent its occurrence. But the younger the person is upon whom it is performed the easier it is accomplished, and provided the general health is good the quicker the wound heals, for the reason that the parts are not fully grown. The prepuce being small and soft is easily removed, whilst the wound left after the operation is small and insignificant."

In the *New York Medical Journal*, Dr. B. M. Rickets says, "In conclusion I would say that so far as I have been able to determine, there has been but one person of the 200 upon whom I have operated who has regretted having had the operation of circumcision done."

In the *Medical Record*, Dr. Henry Levien, in giving two cases and one death produced by a mohel (circumciser) in babies, says that circumcision should be performed by a competent surgeon, or at least under his direct supervision, and in the same journal Dr. R. Hochsoner in answer to Dr. Levien says, "We venture to say that in the best modern hospitals, where Listerism is carried out in a most vigorous way, sepsis occurs a hundred-fold more than in that small crowded room where the mohel is surgeon-in-chief. Circumcision as practiced by the mohel on the infant is no more of an operation than vaccination, opening an ordinary abscess, etc. Permit me further to add that none of our most prominent surgeons ever attacked or ventured an adverse opinion in regard to circumcision, for we never see any evil results from it, and in many cases are sorry our patients have not been circumcised. As a patient of mine, an Arabian, aged 30, upon whom I was compelled to perform circumcision about three months ago, for paraphimosis with extensive sloughing, exclaimed, 'How ungrateful must I be to my father, who neglected his duty to me and left the work to be done by you 30 years afterwards.'"

The following are from the case book of Dr. Herman of Washington: "Wm. T., aged two, suffered from incontinence,

had an elongated prepuce; operated; entirely cured. E. L., aged two, suffered from otorrhea, congestions of head and face, nervous vomitings, difficulty in walking; suffered from congenital phimosis; operated; found two small preputial calculi; child is now well, healthy and robust. W. P., aged fourteen, is subject to seven or eight attacks daily of cyanosis of the face with chil-liness, pulse 160 per minute, passing of flatus per os at intervals of five seconds. Has congenital phimosis with elongated prepuce. He had been treated by one physician for tenia and was at the Children's Hospital for about six months; operated. Boy has had no attacks since. The last Jewish circumcision that I performed was on my cousin's baby. The baby slept during the entire operation. In 36 hours the wound was practically healed. This will, as a rule, always take place, if properly performed and dressed."

In the *Dublin Medical Press* Dr. Joseph Hirschfeld says in discussing the action of Dr. Levit, the German Jewish physician, in refusing to have his child circumcised, on the ground that it is a severe injury, dangerous to the infant and which has been known to prove fatal, Dr. Hirshfeld defends the operation and says it proves fatal in the hands of unskilful operators, adding that every physician having any Jewish patients knows that syphilitic ulcers rarely occur among them, that for the most part they run their course more rapidly, and are seldom followed by secondary phenomena. Especially has he, with them, from the nature of the case, nothing to do with that dangerous chancre which, located on the inner surface of the foreskin and removed from view and treatment, easily increases, eats its way deeply in, becomes indurated, and is followed by the most unhappy secondary and tertiary symptoms. In the same journal Dr. Wm. Mackenzie of Glasgow defends Dr. Levit for his manliness and good sense to refuse to have his child circumcised. He condemns the operation on account of the dangerous hemorrhage which is apt to follow the operation; recites a few cases of severe hem-

orrhage which was stopped by a physician who had been called in. Asks that an inquiry be made by medical men. He ends as follows: The result of such an inquiry might happily be to convince a race of men, enlightened and ambitious enough to aspire to the assuming of the duties of British legislators of the propriety of laying aside a practice, cruel and dangerous.

In the *Annals of Anatomy and Surgery*, Dr. Newton M. Shaffer decries the operation for the relief of patients suffering from what has been called "reflex paralysis," when the condition for which relief was sought was an organic lesion of a great nerve center. He says he has never seen a case of reflex paralysis in a child from genital irritation. His friend, Dr. E. C. Seguin, informs him that his experience is like his own in this respect. He has seen several cases which have been diagnosed as such, but upon examination they proved to be instances of lateral sclerosis of the cord. He claims that in incipient Pott's disease the benefit which they apparently derived from circumcision for a time is due to the rest in bed. And he adds further: "I wish to earnestly protest against certain cases, where there is undoubtedly prepuçal irritation. The indications for this operation are plain and unmistakable, or when, for sanitary or other reasons, circumcision is deemed advisable, there cannot be any objection to it. On the contrary, much good frequently results and many patients have derived permanent relief, from incontinence of urine, frequent priapism, etc. But there can be no doubt, whatever, that in many cases of organic diseases, where the symptoms were very insidious, and hence misinterpreted, the operation has been advised and executed as a means of cure where there was no connection whatever between the so-called reflex symptoms and the frequently inferred genital irritation. In the same journal Dr. W. M. Mastin directs the attention of the profession to a diminution in the size of the external urethral orifice as a direct result of the religious rites of circumcision practiced in early infancy among the Hebrews.

This was discovered by Dr. Claudius H. Mastin of Mobile in an extended urethral practice. His attention was first drawn to the very large number of Jewish youths and adult males who sought advice for gleety or chronic urethral discharges and irritable urethra, and in each case he was surprised to find the meatus narrowed to a degree entirely out of proportion to contractions generally observed, and indeed, usually so much diminished in size as to prevent the passage of a sound bearing even a relative approximation to the urethral caliber. The theory which he advances is briefly as follows: "At the tender age of early infancy (eighth day after birth) the glans penis deprived of its natural protective covering—the foreskin—is exposed at a period when it is covered with a membrane resembling mucous, much more than cutaneous tissues, which is ill adapted to, and is really incapable of resisting the irritative and often inflammatory influences, which this exposure brings about; and hence the atmospheric exposure and the friction by the napkin encircling the child's pelvis, or any rough article of apparel, which it may wear, produces a rapid transition from a semi-mucous to a full cutaneous surface, and thus furnishes the conditions which he believes to be productive of the contraction. These conditions are an alteration in the elements of the covering tissue of the glans which cause a thickening and hardening of the surface of the glans, with exudation of plastic material, especially around the meatus, at which point the line of demarcation between a cutaneous and mucous surface asserting itself, a firm resisting ring is formed, and through the inflammatory deposit here placed, partaking of the character of cicatricial tissue, the edges of the meatus are gradually contracted and, of course, in preparation to the action of the exciting causes.

Dr. C. H. Mastin, in *Gaillard's Medical Journal*, claims that circumcision in the Jew causes stricture of the meatus urinarius externus, and recites three cases. One relaxation with its attendant enuresis; another a loss of the virile

power and unhinging of the nervous system; whilst in the third, a spasmotic condition of a segment of the urethral canal, a perturbation of the nervous forces, with its action on the mental and moral condition of the patient. They were all incised and dilated and perfectly cured by the Jews. He corroborates the observation of Dr. C. H. Mastin of Mobile in regard to the constriction of the meatus which is not uncommon among Hebrews. He ends the article as follows: "As the result of my own reflections, I am induced to place indiscriminate circumcisions in the category of those aberrations that are intended to surpass nature."

Dr. A. B. Arnold of Baltimore says, in the *New York Medical Journal*, that he has circumcised over one thousand Jewish children but does not believe in indiscriminate circumcision and thinks that it should be abandoned.

In an article on "The Barbarity of Circumcision as a Remedy for Congenital Abnormality," Dr. Herbert Snow of London says that this operation is erroneous in principle. It consists in a mutilation. The treatment of congenital phimosis by dilatation is a common sense remedy for this condition. The most conspicuous remote result is that an extremely contracted meatus urinarius is the consequence of subsequent inflammatory processes due to the exposure and continual friction of the unprotected glans. The advantage of circumcision in obviating future venereal contagion is restricted by its principal advocate to one form (albeit the most important) of such disease. Even in this limited field the facts adduced appear open to dispute and greatly to need confirmation by independent observers.

During last winter, through the courtesy of Dr. Larkin W. Glazebrook, one of the visiting surgeons to the Washington City Orphan Asylum, in this city, I was invited to assist in the operation of circumcision on sixteen cases, ranging from 4 to 10 years of age respectively, as an epidemic of masturbation and incontinence of urine had made its appearance in the institution. The perfect result in every case fully justified the

prompt measure, as there has been an absolute cessation of all the trouble. There was but one case that presented any complication, which was secondary hemorrhage, and that could have been avoided, had the bleeding points been ligated instead of included in the sutures. I have in my mind's eye one case who presented himself in the Genito-Urinary and Venereal Service at the Emergency Hospital and Central Dispensary in this city for treatment. Circumcision was at once ordered on account of concealed sore and balanitis; also large vegetations. He being timid, promised to return the following day for the operation, which he failed to do, and today, from lack of it, he presents all the complications possible to ensue. Had he been operated upon when first seen, all his troubles and sufferings could have been in all probability avoided. Of the many times I have

performed the operation, but one case has given much trouble and that was the most obstinate case of balanitis following it has ever been my misfortune to treat. Prior to the operation, the slightest irritation had caused him much suffering from balanitis, but now though two years have passed, he reports absolute freedom from his former trouble. In the Genito-Urinary and Venereal Service of the Emergency Hospital and Central Dispensary, where the service numbers many hundreds of cases per month and is at the same largely composed of the negro race, it is noticeable that more than half seeking treatment are suffering with congenital phimosis.

And now, in the language of our brother, the lawyer, having given, I hope, a fair argument for both sides, "it only remains with you, gentlemen of the jury, to bring in the verdict of guilty or not guilty."

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## A CASE OF INTESTINAL OBSTRUCTION.

By C. J. Wise, M. D.,  
Waverly, Baltimore.

I WAS called to see Mr. W., aged 72 years, suffering with intermittent, colicky pains, mostly in the right abdominal region, and his bowels had been obstinately constipated for one week prior to my first visit, and he had suffered for years previously from this torpid condition; there was slight but frequent mucous discharges and total absence of fecal matter. Vomiting was frequent, but at no period stercoceous.

With these conditions I gave calomel, jalap and rhubarb in sufficient quantities to act as a purgative, but no results following, prescribed croton oil in three minim capsules with no better success. I flushed the lower bowels with soap suds, glycerine and castor oil repeatedly, but it was ejected immediately afterward clear of fecal matter. Confident that I had a case of grave obstruction, no doubt a growth or twisted bowels, I asked a professor of surgery in consultation.

Tenderness upon pressure and tympanites had set in. The extremities were cold and clammy and his condition

became so unfavorable that we concluded the opening of the abdomen offered the least chance for recovery. The surrounding conditions were unfavorable and the relations refused to send the patient to the hospital.

Death followed and the autopsy revealed intestines twisted like the figure 8 at the union of the small with large bowels; with impacted feces. The ascending colon was completely gangrenous, black and thoroughly disintegrated by putrefaction. Peritoneal attachments with the bowels and lining of the abdomen gave evidence of extensive inflammation by contiguity of surfaces. Lower parts of the bowels were entirely empty. The liver appeared healthy but the gall bladder greatly distended with bile.

The question in my mind is, would the opening of the abdomen at such an advanced period of life have offered the least chance of recovery?

Uncertain as to the nature of the obstruction and avoiding the use of opiates (using chemical anodynes instead), was my method of treatment rational?

**SOCIETY REPORTS.****THE CLINICO-PATHOLOGICAL  
SOCIETY OF WASHINGTON, D. C.**

STATED MEETING HELD NOVEMBER 5, 1895.

The meeting was called to order at the office of Dr. Ruffin, and the paper of the evening was read by Dr. T. R. Stone, title CIRCUMCISION. (See page 145).

*Dr. Richardson* opened the discussion by saying that it was a strange anomaly that his position on the list led to the occurrence, at the annual rotation of papers, of his being assigned to discuss papers on subjects as foreign as anything could be to his line of work. He did not know the subject of the paper until this afternoon. While he thought that the promiscuous circumcision of the Jew was wrong, it is one of the rites of their religion and we have no right to interfere. In cases where phimosis is marked, ejection of urine difficult, and considerable irritation and reflex symptoms present, circumcision should be done at once. Even in cases where the phimosis is not so marked, the operation is indicated. In all the cases he has seen the threatening symptoms make it a necessity and the operation gave great relief. When the prepuce is thrown back of the glans the mucous membrane must become partially devoid of sensation and this is one great objection made by the opponents of the operation. Stricture of the meatus is sometimes also produced. These objections are not sufficient to discredit the operation. He has seen some sloughing of the prepuce, and even gangrene of the glans, in cases of phimosis where chancre existed and an operation was indicated.

*Dr. Glazebrook* said that in connection with this subject he would like to cite the case of the Washington Orphan Asylum, where an epidemic of masturbation and incontinence of urine occurred, and was brought to his attention by the matron. One of the boys, aged about ten years, was weak-minded and had spells attributed to epilepsy. In another a case of chorea was present, not so well pronounced, but sufficient to

make out during the physical examination. Incontinence of urine was common. He examined all the boys ranging in ages from five to fourteen years, and invariably picked out the boys who had been found most addicted to these bad habits. They were the boys with elongated preputices. The case of epilepsy one month after the operation had disappeared. He operated upon all the cases affected with incontinence of urine, about fifteen in a crowd of 90. One or two continued for a time after the operation, but only a short while, and all were cured. He thought it was a wise thing to operate on the other boys accused of masturbation, fifteen in number. In all, 35 cases were subjected to the operation. In private practice he had performed the operation upon five or six children and nine adults successfully, and he has always been an ardent advocate of the operation.

One of his cases in private practice was that of a man suffering from spermatorrhea, who had undergone treatment for a long time at the hands of different physicians. He had an elongated prepuce, and after being circumcised was cured in about one month. A second case was one of gleet resisting all the usual treatment. Circumcision was suggested and approved. Good union resulted and for the last three weeks no discharge has occurred. In regard to the operation he would state that in case of one boy in the Asylum there was secondary hemorrhage, but it was caused by the boy urinating and wetting the dressing, and the nurse's efforts to get off the soiled iodoform gauze, resulting in pulling out one of the stitches and slight hemorrhage ensued. As to the number of stitches, we should get the edges as closely adherent as possible, in a child from fifteen to twenty stitches, and in an adult twice as many should be used. By this liberal use of sutures you are sure to get good union and have no secondary hemorrhage. The dressing used is small, and he prefers the moist to the dry; using aristol first and then iodoform gauze soaked in bichloride solution and absorbent cotton over this, but he does not apply a band-

age. In adults he tries to operate on Saturday, never uses anything but cocaine, eight per cent. solution; usually one syringe full suffices; he also uses constriction. He restricts the patients to rest on Sunday, and allows them to go about next day. In preference to not circumcising patients at all, would rather go to the other extreme and operate on all male children.

*Dr. Sprigg* said this question was interesting to the general practitioner. He believes in circumcision, but not in all cases of infants, but in all cases where the prepuce is abnormal. A prepuce that can be readily retracted over the glans and just covers the glans in infancy does not need to be cut. There is no doubt about the relief of nervous symptoms by this operation. His plan in operating is to use enough sutures to bring the parts well together, but avoid using very many or making them too tight. While discussing the subject of male circumcision and the relief of nervous phenomena thereby, we ought not to lose sight of the fact that in some young girls nervous irritability exists that resists all medical treatment. Examination of such cases often shows a condition of adhesions about the clitoris and local treatment will afford relief. He remembers a case of hystero-epilepsy in a grown woman; examination showed the clitoris to be almost concealed by adhesions; excision was done and relief followed.

*Dr. Cole* had operated about 75 times for phimosis for different conditions. In one case of redundancy of the prepuce in an old man, the prepuce had begun to contract and the patient not recognizing the condition had worried about it for many years. The urine in his case was persistently acid. Circumcision was performed and after incision, he found the lower part of the prepuce strongly adherent for two-thirds of its area; the mucous membrane had to be torn and the surface allowed to heal by cicatrization. A case of apparent hip joint trouble now under his care may turn out to be due to a case of adherent prepuce that has been recently relieved.

*Dr. Stone*, in closing, said he had

aimed to give the bulk of the present opinions on both sides of the question of circumcision. He thought that in adults too many sutures could not be used. Infants require none.

*Dr. Sprigg* spoke of a normal prepuce and we must be satisfied that such a prepuce exists before we say circumcision is not required. If ballooning of the prepuce during urination does not occur in infants we may be sure adhesions exist and need relief. Incising the prepuce for concealed chancroids is not popular with him; stretching the prepuce so as to enable us to examine the parts with the endoscope and treat the sore is much better treatment.

R. T. HOLDEN, M. D.,  
Secretary.

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## CORRESPONDENCE.

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### NEW YORK PASTEUR INSTITUTE.

NOVEMBER 11, 1895.

Editor MARYLAND MEDICAL JOURNAL:

*Dear Sir:*—In the November 9th issue of your valued JOURNAL I read in an article written by Dr. Edwin Rosenthal on Diphtheria Antitoxine the following: "Of Gibier's antitoxine I know very little of its strength but the assertion that it equals Roux's. This, however, cannot be substantiated, for an extremely large quantity (25 c. cm.) is necessary as a curative injection, which, if its strength were such, would be unnecessary."

If I was the only one concerned in this matter, though my name is quoted in this article, I would not trespass on your time with this letter; but I am moved by a higher motive, and I have also to think of those who have undertaken the dispensation of the antitoxine prepared at the New York Pasteur Institute. That is why I beg to remark that the argument of the author of this article, who, according to his own statement, has not made any experimental examinations of Gibier's antitoxine, can be summed up as follows: "Gibier's antitoxine being dispensed in larger quantities than others it necessarily

must be weaker." You will agree with me, Mr. Editor, that this is an *a priori* of the weakest form.

In fact, the antitoxine contained in the 7 c.cm bottles as prepared at the Institute would be sufficient in the majority of cases, taken at the incipient stage; but in a large number of cases where antitoxine fails to produce effect, although applied at an early period of the disease, it is due, most of the time, to the insufficiency of the dose. This is why we have deemed it preferable to place in the hands of the practitioners a quantity of antitoxine which would, in some cases, be more than necessary, rather than an insufficient amount.

We have been guided in this determination by a threefold motive: First, fostering the new treatment. Second, helping the physician to obtain better results. Third, to make the price of the new remedy as low as possible at a moment when antitoxine was the object of a speculation which made it obtainable only by the rich.

The statement against which I protest tends to prove that some of our best actions, wrongly interpreted, may be turned against us. Therefore I appeal to your sense of justice, and ask you to kindly insert this letter in your next issue. Yours very truly,

PAUL GIBIER, A. M.; M. D.

P. S.—The New York Pasteur Institute, branch of the Institute of same name in Paris where the science of bacteriology was born, was the first to dispense to the profession in America the diphtheria and other antitoxines. In October, 1894, our serum had attained the maximum obtainable strength and while a dose was difficult to find in America at a rate of \$10, \$20, \$25 and more, we offered it at the same price it is sold today.

**THE DANGERS OF EAR-PIERCING.**—Fournier reports a number of cases of lupus, syphilis and tuberculous nodules from ear-piercing as practiced by jewelers. While such a small operation can be performed by almost any intelligent person, the needle should be thoroughly sterilized by heat and the skin washed.

## MEDICAL PROGRESS.

**LUMBAGO.**—Lumbago is a distressing disease when it is continued and any remedy that gives prompt relief brings comfort to the patient and credit to the physician.

Dr. Albert Robin, in a clinical lecture at the Hôpital de la Pitié, gives a short account, published in the *Bulletin Général de Thérapeutique*, of his method of treating lumbago.

After reviewing the drugs and methods most generally used, he lays especial stress on jaborandi. First examining the case to see that there is no contraindication to the use of this drug, he gives the infusion warm in the morning on an empty stomach. In a half hour there is salivation and sweating. The patient must not swallow the saliva and must keep quiet and not drink water. This treatment causes some nausea. This dose is repeated for several mornings with favorable results and a cure. When jaborandi is not well borne, as in heart disease, he uses hypodermic injections of the glycero-phosphate of soda.

\* \*

**TOPICAL ACTION OF SALOL.**—Columbin (*British Medical Journal*) has been experimenting with regard to the local effects of salol dissolved in liquid vaseline. In the presence of alkaline fluids or living tissues salol appears to break up into salicylic acid and phenol in the nascent state. When split up in this way the author found that, whilst the good antiseptic action of each of the acids was maintained, their irritant action was absent either from the way in which they were set free or from the small quantities evolved. Clinically it was found that salol in vaseline solution—the best solvent—did not irritate the skin nor inflame the ulcerated surfaces which healed under the treatment without pain or local reaction. The author thinks that there may be a useful field opened up in the local application of salol as a non-irritating and sufficiently powerful antiseptic.

MARYLAND

**Medical Journal.**

PUBLISHED WEEKLY.

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BALTIMORE, DECEMBER 14, 1895.

THE death of Dr. J. Edwin Michael, which occurred at his residence, in Baltimore, on the morning of December 7, will bring genuine sorrow and regret to his many friends in this State, and to a large number of his former students, now practitioners of medicine in various sections of this and other countries.

To those who have not seen him during the past few months, who recall his strong and robust appearance and superb physical development, the announcement of his early death in the very prime of manhood will create surprise as well as distress.

During the past two years his intimate friends have noticed marked evidences of physical decay. He had suffered much from neuralgic headaches, had lost flesh and had aged in appearance. His courage, hopefulness and unselfishness led him to speak lightly of his ailments and very few, if any, but those very close to him, were aware of this serious condition of his health. He had

always been proud of his great physical vigor and was reluctant to accept the indications of chronic disease undermining his health. He continued actively at his professional duties when many men of less courage and pride would have found comfort in freedom from care and work. He struggled to the last as he had worked during his entire professional life, proud, courageous and anxious to measure up to his responsibilities. But with a courage which few possess, he yielded to the law of nature and of nature's God that obedience and resignation which belong to the strong and great. If he had pain and regrets in the contemplation of his early end they were born of concern and love for others and not for himself.



He was a man of striking physical, intellectual and personal characteristics. As he towered above the great mass of mankind in stature, so in character and intellect he stood above the shoulders of the great majority. His mind was vigorous, active and strong. Without labor he acquired knowledge and he mastered problems and principles without apparent effort. His natural talents were so apparent to him that he gave less time to study than was sometimes required, and yet he could easily reproduce what many worked more diligently for. He was not preeminently a student, but a thoughtful observer and most careful thinker. He easily mastered any subject presented to his mind, or in which he became interested. Without being a laborious

*The Death of*

*Dr. J. Edwin Michael.*

student he had an unusually well informed mind, a large accumulation of knowledge and uncommon wisdom. His judgment of men, of events and subjects was broad and accurate. His opinions were carefully formed, just and positive. He was narrow in no sense, but broad, liberal and tolerant. He stood upright and his friends and enemies knew just where to find him. There was none of the sham and pretence in his make-up. He was firm and decided in his convictions and upheld them with courage and tenacity. His mind was dominated by a large intelligence, which recognized the highest claims of professional duty, of citizenship and of friendship.

Jacob Edwin Michael was born near Micaelsville, Harford County, Maryland, on May 13, 1848. He was the eldest son of the late Jacob J. Michael, a most respected citizen and large land owner of Harford County. He was raised on his father's farm near the Chesapeake Bay, amidst natural surroundings of great beauty. Force and character thus were given to his early life, which developed the marked characteristics of his later life.

As a boy he had passed much of his time on the shores and waters of the Chesapeake. He ever after loved the sea-faring life. His tastes were rural and he keenly enjoyed his frequent visits to the home of his boyhood. He received his preliminary education at St. Timothy's Hall, Md., and at the Newark Academy in Delaware. He next entered Princeton College, from which he graduated in 1871. Whilst at Princeton he was distinguished for his skill in all of the athletic exercises of the college. At the time of his graduation and when in thorough physical training he was probably the most superb specimen of physical manhood ever graduated from Princeton. He entered the medical department of the University of Maryland, in October, 1871, and graduated in March, 1873. As a medical student he was greatly admired and easily stood in the front rank, being the leader of one of the college factions for the presidency of the class. After graduation he went abroad and passed the subsequent year in study in the best Continental hospitals and schools.

His foreign study was of great advantage in an educational way and exercised a large influence in the development of his professional career. It early opened to him the doorway to professional advancement and whilst

other men of his class were toiling for professional recognition he at once stepped to the front rank and to distinguished professional honors. In the fall of 1874, soon after his return from Europe, he was appointed Demonstrator of Anatomy in the University of Maryland. This position at once offered opportunities for advancement and in 1880 he was promoted to the chair of Anatomy and Clinical Surgery. He thus early entered upon a career as a surgeon and teacher which brought to him both success and distinction. As a surgeon he was cool, painstaking and skilful and in a few years had taken a high rank as an operator. As a teacher he was a success from the beginning. His command of language and his delivery were of a high order so that he became at once an exceedingly popular lecturer and teacher. He was well equipped for professional work and early made progress in professional honors and distinctions. In 1887 he was elected Dean of the Faculty of the University, which position he continued to hold from time to time up to the date of his death. In 1890 he resigned the chair of Anatomy and Clinical Surgery and was elected to the chair of Obstetrics, now made vacant by his death.

He edited the MARYLAND MEDICAL JOURNAL for some six or eight months. He was elected President of the Clinical Society of Maryland and occupied the office for one year.

At the meeting of the Medical and Chirurgical Faculty of Maryland in April of the present year he was honored with the Presidency of the Faculty, now made vacant by his death.

He was a member of the American Surgical Association, of the Southern Surgical and Gynecological Association, of the American Medical Association and of the various local Medical Societies in this city. He was also a member of the University Club and of the Monthly Medical Reunion.

Dr. Michael was married to Miss Susie Mitchell of Harford County in December, 1875. Mrs. Michael and six children, four sons and two daughters, now survive to mourn the loss of a most devoted husband and father.

His remains were buried in the family burying ground near Perryman, Harford County, among his kindred and friends of boyhood who have gone before him. May he rest in peace whilst his memory will ever be dear to a large circle of devoted friends.

**MEDICAL ITEMS.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending December 7, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		26
Phthisis Pulmonalis.....		20
Measles.....	136	3
Whooping Cough.....	1	
Pseudo-membranous Croup and Diphtheria. {	35	18
Mumps.....	1	
Scarlet fever.....	24	
Varioloid.....		
Varicella.....	6	
Typhoid fever.....	1	2

The *Index Medicus* will be republished.

A report from Philadelphia says that the *Medical News* will in the near future be published in New York.

The Mayor of Baltimore did a good thing for the city when he decided to retain Dr. N. G. Keirle as city physician.

Dr. Thomas Keith of London recently died, aged seventy years. He was a distinguished gynecologist and abdominal surgeon.

The St. Louis College of Optical Science has made its debut to the public. The purpose of this concern is to teach opticians to fit glasses.

The loss entailed by the recent fire at the University of Virginia amounted to \$125,000. The medical department was not specially damaged.

Medical inspectors are paid \$1000 a year in Chicago. They are required to pass an examination equivalent to that exacted for entrance into the Government medical service.

Despite the fact that the last Congress reduced the number of officers in the medical department of the army, it is reported that the corps is already nearly down to the new limit. With two retirements recommended some time ago, and that of another officer which occurs in less than ten days, and a fourth in December, the corps will then be

three below the maximum. Accordingly an examination for the vacancies will be held during the next few months.

The Tri-State Medical Association of Western Maryland, Western Pennsylvania and West Virginia held a very successful meeting at Cumberland last Thursday, December 12. After prayer by Rev. Charles E. Raymond of Cumberland, an Address of Welcome was delivered by Dr. W. J. Craigen of Cumberland, which was responded to by Dr. S. H. Gump of Bedford, Pa. The following papers were then read: "Hysterectomy for Puerperal Sepsis," by Dr. Barton Cooke Hirst of Philadelphia; "The Mental Disturbances of the Climacteric Period," by Dr. George H. Rohé of Baltimore; "Iritis," by Dr. J. A. Lippincott of Pittsburg, Pa.; "Benzol Derivatives," by Dr. J. A. Bullock of Lonacouing, Md.; "An Analysis of 160 Consecutive Cataract Operations," by Dr. R. L. Randolph of Baltimore; "Appendicitis," by Dr. C. C. Jacobs of Frostburg, Md.; "Electricity in General Practice," by Dr. A. Enfield of Bedford, Pa.; "Asepsis," by Dr. J. M. Spear of Cumberland. At night a banquet was held at the Manhattan Café, where numerous speeches were made.

On November 6, 1895, the St. Louis Academy of Medical and Surgical Sciences was organized. The constitution of the society subscribes to the code of ethics of the American Medical Association. The membership is limited to fifty. No one can become a member of the Academy unless he possesses a good literary and medical education. As evidence of his literary qualifications and ability as a scientific worker he must deposit with his application, a thesis, a pathological specimen with descriptive text, a drawing of a normal or abnormal specimen with text, or some other evidence of his worth. The evidence is passed upon by the committee on credentials. If the evidence is accepted, the ballot is taken. Two negative votes will defeat a candidate. The following officers were elected for the ensuing year: President, Geo. W. Cale, Jr., M. D., F. R. M. S., London; Senior Vice-President, James Moores Ball, M. D.; Junior Vice-President, Arthur E. Mink, M. D.; Secretary, Emory Lanphear, M. D., Ph. D.; Treasurer, Wellington Adams, A. M., M. D.; Orator, Thomas O. Summers, A. M., B. S. M. R. C. S., Eng., M. D.; Curator, George Howard Thompson, A. M., M. D.

## WASHINGTON NOTES.

The Clinico-Pathological Society held its regular meeting on Tuesday evening, December 3, the President, Dr. H. B. Deale, in the chair.

Dr. John Van Rensselaer was the essayist of the evening; his paper was entitled, "Empyema; the Report of a Case." It was thoroughly discussed by Drs. Louis Mackall, L. W. Glazebrook, A. A. Snyder and Sterling Ruffin. Dr. Glazebrook presented a lung of a person who had died from Empyema. It only weighed one-half as much as that of the other side and was as tough as leather. The plan for having a banquet was postponed until February.

The Washington Obstetrical and Gynecological Society held its regular meeting on Friday evening, December 6, the President, Dr. George Byrd Harrison, in the chair. Dr. H. L. E. Johnson presented a hymen, which had been torn away from its junction with the vaginal walls by sexual intercourse. It was still firmly attached at its upper border, but was flapping and serving as an irritant, so was removed under cocaine. Dr. F. S. Nash read a paper which was entitled, "A Plea for the new Woman and the Bicycle." It was discussed by Drs. W. P. Carr, S. S. Adams, W. S. Bowen, H. L. E. Johnson, E. L. Tompkins and J. Wesley Bovée.

Dr. J. R. Bromwell reported an interesting case of Placenta Previa, with twins, in which both twins and the mother were saved and are still doing well. It was most liberally discussed by Drs. Jos. Taber Johnson, H. L. E. Johnson, T. C. Smith, J. Wesley Bovée, A. F. A. King, W. S. Bowen and M. F. Cuthbert. The Society then adjourned.

The Medical Society of the District of Columbia held its regular weekly meeting on Wednesday evening, December 4. It was a most interesting meeting. The President, Dr. Samuel C. Busey, in the chair. The discussion for the evening was on "The Clinical Aspects of Diphtheria, Treated by its Antitoxine," which was joined in by Drs. C. W. Richardson, S. S. Adams, J. J. Kinyoun, Walter Reed and others.

A competitive examination will be held on December 20, at 8 o'clock p. m., at the Emergency Hospital, to fill three vacancies in the House Staff.

Dr. George M. Kohn, who was appointed

Special Sanitary Officer to investigate typhoid fever in this city, has submitted his report. Of the 500 cases selected, 436 were contracted at home, the remaining 64 elsewhere, 17 of them being from Colonial Beach. Of those contracted here, 289 were consumers of well-water. Of the 421 infected houses, 261 had sewer connections, 152 had privies, 2 had cess-pools, 4 had surface privies or sinks, and 2 had no privies. It was said recently that some of the cases of typhoid fever had originated in the Treasury Building, but the Health Officer, after a thorough investigation as to the sanitary condition, found no evidence for any such assertions. There was only one death from diphtheria last week in this city, four from typhoid fever, five from apoplexy and sixteen from pneumonia.

## PUBLIC SERVICE.

## UNITED STATES ARMY.

*Week ending December 9, 1895.*

Captain William H. Arthur, Assistant Surgeon, is relieved from duty at Fort Columbus, New York, and ordered to Fort Myer, Virginia, for duty.

## UNITED STATES NAVY.

*For One Week ending December 7, 1895.*

Assistant Surgeon George C. Hubbard detached from instruction at the Naval Laboratory, New York, and ordered to the "Vermont."

Passed Assistant Surgeon E. R. Stitt detached from the "New York" and ordered to the Coast Survey Steamer "Bache."

Passed Assistant Surgeon G. H. Barber detached from the "Bache" and ordered to the "New York."

## UNITED STATES MARINE SERVICE.

*Fifteen days ending November 30, 1895.*

C. S. D. Fessenden, Surgeon, placed on waiting orders, November 22, 1895.

F. W. Mead, Surgeon, granted leave of absence for thirty days, November 21, 1895.

W. P. McIntosh, Passed Assistant Surgeon, to proceed from Boston, Mass., to Portland, Maine, for temporary duty, November 25, 1895.

W. J. Pettus, Passed Assistant Surgeon, relieved from duty at Buffalo, N. Y., and directed to proceed to Cape Charles Quarantine, and assume command of Station, November 16, 1895.

G. M. Magruder, Passed Assistant Surgeon, granted leave of absence for thirty days, November 20, 1895.

T. B. Perry, Passed Assistant Surgeon, relieved from command Cape Charles Quarantine and directed to proceed to Buffalo, N. Y.,

and assume command of Service, November 16, 1895.

W. G. Stimpson, Passed Assistant Surgeon, granted leave of absence for thirty days, November 20, 1895.

L. E. Cofer, Assistant Surgeon, placed on waiting orders from December 1, 1895, November 21, 1895.

J. A. Nydegger, Assistant Surgeon, when relieved from temporary duty at Mobile, Ala., to rejoin his Station at Savannah, Ga., November 27, 1895.

W. J. S. Stewart, Assistant Surgeon, granted leave of absence for fourteen days, November 29, 1895.

E. K. Sprague, Assistant Surgeon, relieved from temporary duty at Key West Quarantine and directed to rejoin his station at Mobile, Ala., November 27, 1895.

Emil Prochazka, Assistant Surgeon, to proceed from Detroit, Mich., to Buffalo, N. Y., for temporary duty, November 16, 1895.

J. B. Greene, Assistant Surgeon, granted leave of absence for thirty days, November 20, 1895.

## BOOK REVIEWS.

**HERRICK'S DIAGNOSIS.** A Handbook of Medical Diagnosis. By James B. Herrick, M. D., Adjunct Professor of Medicine, Rush Medical College, Chicago. In one handsome 12mo. volume of 429 pages, with 80 engravings, and 2 colored plates. Cloth, \$2.50. Philadelphia : Lea Brothers & Co., Publishers, 1895.

This is one of many good books of its kind and differs little from others now in use. A careful perusal fails to show anything characteristic or warranting its appearance, but it is none the less a good book, especially for students. The author has made free use of cuts from similar works. He has adopted the word "Anamæsis."

**A TREATISE ON NERVOUS AND MENTAL DISEASES.** By Landon Carter Gray, M. D., Professor of Diseases of the Mind and Nervous System in the New York Polyclinic. New (2d) edition. In one very handsome octavo volume of 728 pages, with 172 engravings and 3 colored plates. Cloth, \$4.75 ; leather, \$5.75. Philadelphia : Lea Brothers & Co. 1895.

The first edition of this excellent work has already been reviewed in these columns. The present volume has been thoroughly revised and five new chapters on Dementia, Dementia Paranoides, Confusional Insanity, Delirium and Massage have been added. New plates have been made and old ones re-executed and the book, useful alike for physician and student, has been brought down to the present time.

## CURRENT EDITORIAL COMMENT.

### PRACTICALITY IN MEDICINE.

*New York State Medical Reporter.*

WE regard the man as successful in the highest sense who does his own thinking and acts out the convictions to which it leads. This is the highest type of practicality.

### A PRELIMINARY EDUCATION.

*The Medical Herald.*

FOR quite a time we have heard much on the general absence of suitable education on the part of young men who enter on the study of medicine. The much that has been published on this subject is an indication of the lack of this fitness. The consequence has been an awakening on the subject, and some very positive expressions of opinion have been given. What has been said has borne some fruit.

### DOCTOR'S BILLS.

*Canadian Practitioner.*

IT appears to be pretty generally recognized among the laity that the doctor's bill is about the last that ought to be paid. It is only fair to say, however, that the doctors themselves are largely to blame, on account of their unbusiness-like habits and want of regularity and promptitude in sending out their accounts. Our profession, fortunately, is now more highly respected by the public than ever before. This is, probably, especially true in Great Britain, where the social and general status of the physician or surgeon is much higher than it was twenty-five years ago.

### THE PASSING OF ANTISEPSIS.

*Northwestern Lancet.*

WITH an increase of knowledge of the principles that underlie the prevention of fermentative processes in wounds come a greater simplicity in the measures necessary to be taken to secure union by first intention. It is a far cry from the early days of Listerism with operating rooms filled with the spray of half a dozen atomizers and with complicated dressings of many materials to the perfected steam sterilizer of the present day, which, in the half-hour before the operation, renders aseptic everything needed for operation or dressing, including the aprons worn by operator and assistants, and leaves nothing to be done but the cleaning of hands and of the part to be operated upon.

# MARYLAND MEDICAL JOURNAL

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## ORIGINAL ARTICLES.

### A CASE OF DIPHTHERIA TREATED BY ANTITOXINE.

By George S. Hull, M. D.,  
Chambersburg, Pa.

THE following case of diphtheria treated by antitoxine is considered worthy of being reported because the writer had the opportunity of seeing it very frequently and watching both the progress of the disease and the effects of the remedy.

During the first day of the disease the child (5 years of age) complained of aching in the back and limbs, followed by soreness of the throat and slight elevation of temperature in the evening. Aconite and belladonna were given alternately, and at midnight, on account of restlessness,  $2\frac{1}{2}$  grains of Dover's powder. On the second day, at 7 A. M., this temperature was  $103\frac{1}{2}$ °, and the pulse 130. There were whitish patches forming on the apices of the swollen tonsils, and the cervical glands were beginning to be infiltrated. A mixture of equal parts of Monsel's solution and glycerine was applied and the application repeated at intervals of two and a half hours. Also were given, every three hours, twenty drops of tincture of ferric chloride with one grain of potassium chlorate. In the evening the temperature had fallen to 99°, and the pulse to 110.

On the third day the morning temperature was  $99\frac{1}{2}$ °, and the pulse 112. The treatment was continued as on the previous day. The evening temperature registered 100°, and the pulse was 120.

The child had passed a fairly comfortable day. On the fourth day the morning temperature was 100°, and the pulse 120. The child was becoming restless and anxious and refused to take nourishment. The membrane in the throat seemed to be increasing, and the child was experiencing some difficulty in breathing through the nostrils. A culture was made from the membrane and sent to Dr. Bolton of the Philadelphia Bacteriological Laboratory for examination. The evening temperature was  $100\frac{1}{2}$ °, and the pulse 140.

On the fifth day the membrane was found to have invaded the nasal cavity to a large extent, completely shutting off nasal inspiration. Morning temperature was 100°, and pulse 140. The child was very restless. The signs of exhaustion were multiplying rapidly, and the case presented a hopeless aspect. The report from Dr. Bolton read: "Large number of diphtheria bacilli." At 4 P. M., when the temperature was  $100\frac{4}{5}$ °, and the pulse 160, an injection of 8 c.c. of Mulford's antitoxic serum (containing 800 immunity units) was given. The syringe was kept in boiling water ten minutes before using it. The place selected for the injection was the loose tissues over the abdomen, low down on the right side (selected so that the child's movements would not be so much limited should an abscess result from the

injection). The skin in this vicinity was rendered thoroughly aseptic.

On account of the large amount of serum to be placed under the skin, it was thought best to make two punctures, about an inch apart, thus avoiding tearing up so much tissue at one spot, and also saving time by being thus enabled to force in the smaller amounts more quickly. After the injections the child complained at times, for an hour, of burning pain in the region, caused mostly by the trikresol, or other antisепtic mixed with the serum to preserve it.

The first effect noticed was a lessening of the restlessness. The temperature remained stationary ( $100\frac{4}{5}^{\circ}$ ) until 3 A. M. of the sixth day, when the child fell into a sound sleep lasting two hours. On awakening, the temperature was  $99^{\circ}$ . At 7 A. M. it was  $98\frac{3}{4}^{\circ}$ . The pulse came down to 105. During the day the child brightened and began to take nourishment, chiefly bovinine and milk. The evening temperature was  $99\frac{1}{2}^{\circ}$  and pulse 110. The membrane was pultaceous and seemed to be loosening and coming off in shreds. Applications to the throat, which had been infrequent since using the antitoxine, were now discontinued on account of the tendency of the parts to bleed upon slight irritation. On account of the marked improvement the injection of serum was not repeated (subsequent history of this case shows that the one injection was sufficient, but it is best to repeat it one or more times in severe cases).

On the seventh day after some discharge through the nostrils, the child could again breathe through them. The throat was free from membrane, save a small patch on the left arch of the palate in front. The temperature kept near to normal, and there was rapid improvement in every respect. From this time the recovery was uninterrupted. On the eighth day no membrane could be seen. Cultures were made from the secretion of the throat, at intervals of two or three days, and the reports from Dr. Bolton showed the presence of bacilli as long as twelve days after the membrane had entirely disappeared from the throat. By this time the child was able to enjoy

and profit by the air and sunshine of out-of-door life and did so, but was kept isolated from other children and adults, until the bacteriological examination showed the absence of bacilli from the cultures. During convalescence strychnia and iron were made use of.

There was no other manifestation from the injection of this antitoxine save the curative effect, in this case. Occasionally exanthematous eruptions are reported, but they cause but a temporary annoyance.

The fact that the presence of virulent bacilli were detected in the throat for days after the child was able to be taken out of doors emphasizes the importance of keeping cases of diphtheria isolated until the cultures show the absence of bacilli. Undoubtedly many children are infected by diphtheritic patients, who have been discharged before the bacilli have entirely disappeared from their throats. Sometimes physicians and nurses carry diphtheria bacilli in their throats, without having the disease, during epidemics, and are thus in position to give the disease to those more susceptible to it.

The antitoxic serum does not kill the bacillus of diphtheria, but it gives to the system something which makes it no longer a good feeding ground for the germ, and so it lets go its hold and is thrown off. The curative effect seems due to its giving to the system the power needed to oppose effective resistance to the toxine of the bacillus; also as the toxine lessens the action of the leucocytes in throwing out what of the bacilli may enter the circulation (most of the bacilli are cast off by the membrane in the throat, but it is claimed that some do enter the blood), the antitoxine prevents this lessening of the power of the leucocytes to act as phagocytes.

Whether the action of the antitoxine is a chemical or vital one is not clearly settled, but on account of the small amount needed, it most likely acts through the living cells increasing their power to oppose resistance to the toxine, or at least preventing the toxine from lessening this power.

Evidently the earlier the antitoxine is used the better. After the fourth day the chances of obtaining a favorable result from its use diminish very rapidly. Where there has been marked necrosis of the cells produced by the long-continued action of the toxine the antitoxine treatment is powerless to restore them.

Cases of mixed infection seem not so favorably influenced by the serum. It seems to have but little power over the sepsis caused by the streptococcus, sta-

phylococcus, etc. This fact shows the importance of keeping up local treatment in conjunction with the antitoxine treatment.

As it is claimed that from one hundred to two hundred units of antitoxic serum will give almost certain immunity to an adult for four weeks, the wisdom of injecting the serum into the other members of a patient's family, especially where complete isolation cannot be effected, is apparent.

## THE TREATMENT OF INFLUENZA.

*By Thomas H. Buckler, M. D.,*

Baltimore.

WHEN, in 1892, I published in the MARYLAND MEDICAL JOURNAL a paper of ten pages on the etiology and history of influenza (*la grippe*) nothing was said about the treatment, which is, after all, a simple matter and is here given in the following brief words, whether the disease is ushered in, in the usual way, with *courbature* (muscular aching all over the body) or primarily as a rheumatic sore throat (*tonsilitis*) converted rapidly by metastasis into endocarditis, of which Bishop Brooks died, or commences as a rheumatic bronchitis which, transferred to the heart, caused the death of the poet Browning at the Palazzo Rezzonico, on the Grand Canal, at Venice.

Influenza is always a rheumatismal disease and as such must be treated. Therefore give at the instant of the seizure our old-fashioned Dover's powder, the active ingredients of which are one grain of opium, one grain of ipecac, with eight grains of sugar of milk, to give it bulk.

If the seizure of this malady is during the day, put the patient to bed as soon as possible and give the Dover's powder. After a sleep of six or seven hours, give, dissolved in water, fifteen grains of salicylate of sodium and repeat this dose every six or eight hours; and, to facilitate the sweating caused thereby, cover up well with warm blankets. Four of

these powders are usually sufficient to sweat and stamp out the disease, and there is an end of it, but if further required the salicylate may be continued without stint at regular intervals, as already stated.

Both in Paris and here I have never known the most violent case of this disease to detain a patient in bed longer than two or three days at most. The above treatment was adopted at the very beginning, and fearing the seizure might be at night, the above simple remedies were always kept in the house.

But when this treatment is not adopted at once and carefully carried out the morbid elements may fly to some vital organ, causing detention in bed for weeks and not infrequently loss of life afterwards, or months or years of more or less suffering.

The use of a Dover's powder followed by salicylate of sodium is so wholly and entirely the proper mode of treating influenza that no other method need for one moment be entertained or made a subject for inquiry or experiment. The Dover-salicylate is not only the best treatment for complicated influenza, but the best for the visceral rheumatism which in many cases attends or rapidly follows it and as no time should therefore be lost in giving the salicylate, the first dose of it may be given cotemporane-

ously with the Dover's powder and the other single doses continued at the intervals already stated.

The most usual visceral complications are rheumatic nephritis, rheumatic or gouty inflammation of the gall ducts, fibro-bronchitis, incipient pneumonia,

and incipient endo- and pericarditis, the two last being most generally preceded by rheumatic bronchitis, and the outcome usually pronounced "heart failure" by those unacquainted with the pathology of rheumatism.

## THE BURIED TENDON SUTURE.

REMARKS MADE AT THE MEETING OF THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

By H. O. Marcy, M. D.,  
Boston, Mass.

AT the recent meeting of the Southern Surgical and Gynecological Association held in Washington, Dr. Marcy of Boston read an interesting and instructive paper upon the history of the buried animal suture, and the best methods for its preservation and use. Since Dr. Marcy was the first to suggest the use of buried sutures and demonstrate their value, his contributions upon this subject are of more than ordinary importance.

His first contribution upon the buried catgut suture was in 1870. In 1880, he substituted tendon for catgut as in every way superior and in many articles has called the attention of the profession to the importance of their general adoption.

Dr. Marcy stated that the defect of catgut is inherent in its structure and cannot be rendered satisfactory by any method of preparation. The connective tissue sheath of the intestine of the sheep from which catgut is manufactured has its ultimate fiber disposed in an oblique direction, crossing diagonally. This serves the physiological purpose of permitting foreshortening and distension as well as strength. The violin string, catgut of commerce, is not unlike a very thin piece of tissue silk which has been cut diagonally and then twisted. This would make a very imperfect fish line and Dr. Marcy thinks the comparison not overdrawn. When dry the gut is strong, but when wet is flat, elastic and slipping.

Chromicised tanning only partially remedies this deficit, and sterilization by any process cannot correct the damage which the intercellular cement substance has sustained from the bacterial infection and maceration processes, to which, in preparation, the catgut is necessarily subjected. Properly prepared tendon not only escapes these injuries, but has an ultimate entirely different construction. The connective tissue cells are disposed parallel to each other and are the strongest structures of the animal economy. Of equal weight, carefully selected tendon will sustain a tension equal to that of a silver wire.

Tendons taken from the freshly killed animal are quickly sun-dried and kept dry until their final preparation. Soaked in a  $\frac{1}{1000}$  mercuric solution until supple, the tendons are carefully cleaned, assorted and dried between sterilized towels. They are then chromicised until of a dark golden yellow and preserved in sterilized linseed oil to which  $\frac{1}{10}$  part of the crystals of carbolic acid has been added. Sutures thus prepared improve by age. When desired for use they are soaked in  $\frac{1}{1000}$  solution of bichloride of mercury until supple. Preserved in absolute alcohol, boiled in it under pressure, boiled in kumoal (oil of canary seed), indeed, prepared by any of the many ways suggested for the sterilization of catgut, serve only to injure the inherent structure of tendon and are not to be commended. The tendons from the tail of the smaller varieties of the kangaroo

furnish by far the most valuable suture material yet found. The anatomical construction of the psoas muscles of the rat, squirrel and the opossum is not unlike that of the kangaroo, each fasciculus having its independent tendon extending the entire length of the tail. The tendons of these smaller animals are too short and fine, those from the large kangaroo too large. The latter, when subdivided, fray and are less valuable. Dr. Marcy reported that from various sources kangaroo tendon has recently been put upon the market which is very defective. One lot of three hundred pounds, collected for him, was almost entirely from the large kangaroo, and so undesirable that he refused its acceptance. This, at a price, has found its way into the American market and is being distributed to the profession. Selected tendon should be furnished at ten dollars per hundred, although usually sold at a much higher price.

Dr. Marcy has secured reliable parties who prepare the tendon, subject to his supervision, and it may be obtained at this price by addressing him. Dr. Marcy

APPENDICITIS.—Appendicitis may be a formidable disease, but the treatment by surgical interference has better results than formerly. Dr. J. H. Carstens, in making some remarks on this disease, in the *Journal of the American Medical Association*, says that physicians in the country see so few cases because one case of this disease occurs in five thousand of the population and as there is only one physician to less than five hundred of the population it stands to reason that the country practitioner sees very few cases. In the city everyone is on the lookout for it and few cases escape. He lays down the following rules:

1. That the general practitioner with a good fair practice will hardly see more than one case a year on an average.

2. That peritonitis always is appendicitis and will be readily diagnosed by every practitioner if he will only look for it.

3. That all cases of appendicitis should be operated upon as soon as diagnosed, because the danger is almost *nil* before

closed his paper with an account of his many histological experiments upon animals, and of his large surgical experience, and expressed the belief that all aseptic wounds, including even the larger amputations, should be closed in layers by buried tendon sutures without drainage, the edges of the skin being coapted by means of a parallel continuous buried suture (sub-cuticular) and the wound sealed with iodoform collodion, strengthened by a few fibers of cotton. The advantages of the buried tendon suture are briefly as follows: Aseptic, buried in aseptic wounds, they remain aseptic and the repair is primarily without either inflammation, pain or suppuration.

The iodoform collodion seal renders subsequent infection impossible. No sutures are to be removed and no other dressing is required. The tendon is absorbed so slowly that it may be traced in the tissues months after implantation and ultimately is replaced by a band of vitalized connective tissue which serves as a permanent reinforcement of the united structures.

rupture, but after rupture even an operation will not always stay the progress of the septic condition.

\* \* \*

TREPHINING IN CHOKED DISC.—Angelucci (*British Medical Journal*) reports three cases of cerebral lesions causing edema of the optic disc, in which trephining was followed by considerable improvement of vision. The first case was one of hemiplegic epilepsy. After trephining the papillary edema disappeared; vision was so far regained as to allow the patient to perform the grosser offices of a housewife; the fits and the headache also ceased. In the second case of cerebellar lesion (unsteady gait, vertigo, acoustic symptoms, etc.), with double bilateral edema of the discs, improvement of vision followed almost immediately after the operation. In the third case in which the symptoms were more severe and in which a cerebellar tumor was diagnosed, improvement also followed, but to a slighter extent.

**SOCIETY REPORTS.****SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.**

ABSTRACT OF THE PROCEEDINGS OF THE EIGHTH ANNUAL MEETING, HELD IN WASHINGTON,  
D. C., NOVEMBER 12, 13 AND 14, 1895.

**SECOND DAY, AFTERNOON SESSION.**

The President's Address was delivered by Dr. L. McLane Tiffany of Baltimore. Dr. Tiffany said the aim of the Association is twofold; first, to do advanced work; and second, to bring it to the notice of, and aid other members of the profession. The one complementary to the other, neither complete alone, yet attaining full fruition when associated. The fellowship of the Association is a very extended one, embracing a territory of many degrees of latitude by many degrees of longitude, with infinite varieties of soil, temperature, environment, etc., yet the transactions did not show those exact local records from which facts may be generalized, applicable to the whole area, or a large part of the area, from which the fellowship is drawn. It did not seem reasonable to him to suppose that a surgical operation done among the mountains of Western North Carolina was going to behave quite the same way that a similar operation would if done on the Gulf coast of Texas. It did not seem reasonable that similar surgical operations on the bank of the Mississippi and the Central Plateau of Tennessee would behave the same way. Accurately kept charts with exact and careful notes would unquestionably show differences not yet put on record by anyone from which much clinical information could be learned. Again he questioned whether surgical operations undertaken during the great heat of summer, or after long continuance of summer heat, would show similar charts or give like results when compared with operations upon patients not subjected to high atmospheric temperature, either temporary or of long continuance. No association had a membership better situated or more competent to carry on a series of such investigations.

*Dr. Willis F. Westmoreland* of Atlanta, Ga., made some remarks on "Cystotomy for Stone." Among other things, the author said that any surgeon of the present day, who had had a long and extensive experience in operating for stone, must acknowledge that the upper operation of cystotomy is better and safer. Unless there is a pathological condition of the blood or infection of the bladder, as recognized by chemical or microscopical examination, the surgeon could decide before operation what course to pursue. The anatomy of this region as laid down by the investigations of Strong and Petersen upon the cadaver and frozen sections leads the surgeon astray, and the observation of the practitioner is more to be depended upon than any literature we have thus far relative to the subject. In operations for stone, the author said he cares not whether he sees the base of the bladder; that he depends upon touch, and that therefore rectal distention might be dispensed with. Instead of rectal distension, he recommends that a vessel of water be suspended three or more feet above the patient, according to the amount of distention necessary. Where the surgeon desires to effect distention of the bladder by a vessel, if the bladder is ulcerated at any point, with a thickening here or thinness there, it could be done without sudden force, and if the patient during the operation should sneeze or cough, or contraction of the bladder take place, instead of contracting upon a solid mass of fluid, the fluid is forced back into the vessel and there is practically no increase in pressure.

*Dr. Cornelius Kollock* of Cheraw, S. C., read a paper entitled "Abdominal Pregnancy." After referring to the pathology of extrauterine fetation and the classification of its varieties by early writers, he reported the following case: October 18, 1894, he saw for the first time a dark mulatto, 34 years of age, the mother of three children, whose general health had been good until within the last fifteen months. The abdomen was very much distended, measuring at the umbilicus 63 inches. Fluctuation was evident and wave tap very

distinct. The patient affirmed that she was pregnant, and that she had gone four months beyond the actual period of gestation. After a thorough examination laparotomy was decided upon, and an incision was made four inches in length below the umbilicus. The walls were so thin that the instrument penetrated the cavity before it was certain that the abdominal muscles were divided. There was a sudden and copious discharge of offensive matter. An immense fibroid was removed from the anterior portion of the sac. The cavity also contained a fetus weighing ten pounds. The placenta had undergone fibroid degeneration, with only a small part of the placental tissue remaining. The patient was extremely weak when operated on. She lived comfortably for five or six weeks after operation, and Dr. Kollock thinks she would be alive today were it not for the unfortunate intervention of intestinal obstruction.

*Dr. J. T. Henry* of Chester, S. C., followed with a paper in which he reported "A Case of Extrauterine Pregnancy." In this case the abdomen was freely opened and a large dark mass nearly as large as the head of an adult came into view. The uterus was crowded very much forward. The mass lay posterior to it and was very much adherent to the fundus posteriorly and to the promontory of the sacrum. The fimbria of the right tube spread out over the covering of the mass. This mass was with some difficulty freed from its attachments except that portion to the fundus of the uterus, and it was thought best to remove the uterus with it, which was done after tying and cutting the broad ligaments. The fetus was five inches long and lay between the placenta and the uterus, the cord being attached to the left margin of the placenta. The abdomen was thoroughly washed out with sterilized water and closed without drainage. Patient sat up on the fourteenth day after operation and was out of bed in twenty-five days. She has gained twenty-five pounds in weight since operation.

*Dr. Henry O. Marcy* of Boston read a paper entitled "The Technique of the Buried Suture." (See page 166.)

One of the interesting features of the meeting was the presentation of a gavel made from the leg of the operating table used by Dr. J. Marion Sims in his office for twelve years preceding his death. It was the gift of his son, Dr. H. Marion Sims.

The following officers were elected: President, Dr. E. S. Lewis, New Orleans, La.; First Vice-President, Dr. Joseph Taber Johnson, Washington, D. C.; Second Vice-President, Dr. Richard Douglass, Nashville, Tenn.; Secretary, Dr. W. E. B. Davis, Birmingham, Ala.; Treasurer, Dr. A. M. Cartledge, Louisville, Ky. Place of Meeting, Nashville, second Tuesday in November, 1896. Chairman of Committee of Arrangements, Dr. W. D. Haggard, Nashville, Tenn.

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#### CLINICAL SOCIETY OF MARYLAND.

MEETING HELD NOVEMBER 15, 1895.

The 313th regular meeting of the Clinical Society of Maryland was called to order by the President, Dr. J. M. Hundley.

A letter from Dr. W. S. Thayer was read, in which he stated that owing to a press of other business he was compelled to resign the office of Chairman of the Executive Committee to which he had been recently elected. The resignation was accepted and Dr. R. L. Randolph elected to the vacancy on the Committee, Dr. S. K. Merrick becoming Chairman.

The first paper of the evening was read by Dr. Samuel Theobald; "Observations Upon Some Points in the Technique of Cataract Extractions."

Dr. Theobald said that one of the first points to consider in cataract extractions was the method of operating. We have to choose between the simple and the combined extractions. He gave as the advantages of simple extraction—"small central pupil, less iritis, entrance of germs less easy, and less likelihood of loss of vitreous and of incarceration in the wound of bits of capsule." The disadvantages are "larger section required, iris more apt to fall before the knife and be cut, greater difficulty in getting out

the cortex and delivering the lens, prolapse of iris (which occurs in ten to fifteen per cent. of cases), and greater amount of corneal astigmatism."

Dr. Theobald thought the indications for simple extraction were "fully mature cataract, a large cornea, a pupil which is responsive to atropia and a quiet and tractable patient" and that wherever these conditions are not all present, the combined extraction should be done. He called attention to the fact that most simple extractions had been done on selected cases and that this should be borne in mind when comparing results. "The round pupil gained by the simple method gives a slightly better cosmetic effect, but the coloboma produced by iridectomy is covered by the upper lid and probably does not lessen the visual acuteness. Simple extraction has yet to stand the test of time. Serious secondary troubles, such as sympathetic ophthalmitis and purulent irido-choroiditis, may yet be reported as consequences of the numerous instances which occur of extensive incarceration of the iris in the corneal section." The fate of Critchett's operation of iridodesis, at one time in general favor, but now abandoned by all, was referred to in support of this view.

His section is made throughout in the corneal limbus and may or may not have a conjunctival flap. He considers this method better than finishing in the clear cornea because it leaves no scar and produces less astigmatism. The iridectomy he makes by one cut with the scissors and the edges of the iris are carefully replaced, to avoid incarceration. The shape of the rent in the capsule is probably not important.

In speaking of the maturity of cataracts Dr. Theobald said it was difficult to lay down a definite rule. One of the tests usually given is, that the patient shall fail to count fingers. He said he had frequently seen perfectly mature cataracts, especially the amber-colored cataracts of old age, with ability to count fingers at several feet, and on the other hand many cases that showed much worse vision (cataracts giving the mother of pearl reflex) which were not matured.

As to antisepsis, he always holds his knife in boiling water and washes it by means of a bit of absorbent cotton (sterilized by boiling), held in the forceps. All the other instruments are placed directly in the boiling water. To treat the knife so would dull its cutting edge. He sharpens his knife before each operation by stropping it on an ordinary razor strop, and finds that he can produce a better cutting edge in this way than the instrument maker usually gives. The conjunctival sac is flushed several times with sol. hydrarg. bichlor., 1 to 8000, and the lids washed with the same solution. The solution of cocaine (cocaine 4 per cent. and boric acid 2 per cent.) is sterilized by boiling, just previous to use. By keeping the lids closed during the application of the cocaine, anesthetization occurs quicker and the cornea does not become so dry and hard.

Dr. Theobald always uses the Murdoch speculum and thinks it much better adapted to operations on the eyeball than any other speculum. It is light, holds the lids firmly, exerts a minimum degree of pressure upon the eyeball and is so curved that it is never in the way of the operating hand. At the Baltimore Eye, Ear and Throat Charity Hospital special trestles, made for the purpose, are slid under the bed to raise it to a convenient height for operating. When the operation is over they are easily removed and the bed lowered to the floor without disturbing the patient. Thus perfect quiet is given the patient from the time of the operation. After the operation Dr. Theobald uses adhesion plaster dressings for each eye, and in nervous or excitable patients a cotton pad besides, held in place by plaster strips, upon the operated eye, as an extra precaution. The eyes are kept closed until the third day, when the wounded one receives an application of atropia and is again closed, while the other is left open.

Dr. Theobald spoke of the various shields and masks that had been suggested to protect the eyes after operation and exhibited the mask devised by Dr. Ring.

In speaking of the state of refraction

after cataract operations he said he had found astigmatism, against the rule, present in many cases.

#### DISCUSSION.

*Dr. Hiram Woods:* I have been very much interested in this paper and would like to add a few words on the subject. First, as to the selection of cases for the simple extraction, the objection made, that most of the successful simple cases were selected, is legitimate. There should be some basis upon which to make this selection. What shall that basis be? What are the main advantages of simple extraction?

1. The better appearance of the eye.
2. Less danger of infection.
3. Less danger of prolapse of vitreous.
4. The sight is claimed to be better.

I do not believe more than one of these holds good and that is the improved appearance. The operation is somewhat more difficult, but not much, and besides, the operator should know how to master these difficulties. We come then down to the appearance as the main advantage of the simple extraction. I know it is a great temptation, when you see the pupil go back nicely into the anterior chamber, to let it alone, and I know, too, that if one does let it alone he is on the anxious bench for forty-eight hours. If at the end of that time the eye is doing well I congratulate myself, if there is a prolapse I feel very badly. A few days ago, while preparing to remove a cataract, the patient said to me: "Doctor, I want you to remember that my living depends on my getting my eyesight, I want no experiments." I performed an iridectomy. I am inclined to think that for myself I would not run the risk of a simple extraction. Yet I confess that I think it is in the line of scientific work to do simple extractions.

I did 19 simple operations without a hernia and followed this with another set of 4 or 5 with but one prolapse. In the last few cases, however, I have had pretty hard luck and cannot tell why. I do not believe the corneal section has much to do with it. Some one has suggested that we make a small opening in

the iris near the corneal section (in accordance with the generally accepted view that prolapse is caused by the aqueous washing out the iris before the corneal wound is strongly enough united to hold against it), other methods are to contract the pupil by eserine or to dilate it by atropia. Of the last two methods, I am inclined to think the atropia best.

Dr. Bateman has published twenty-five cases treated by atropia in which he had but two prolapses. In all the atropia was used both before and after the operation, and then the eye let alone for three days. I did two operations in this way and both prolapsed. I did two without atropia and both did well. By the use of eserine I believe you would be simply courting a prolapse. The safer operation, I am convinced, is that with an iridectomy. The vast majority of surgeons are coming back to this view. There are certain things the iris may do, after an operation, which demand an iridectomy. One is that if the iris persists in coming up to the section and the pupil will not stay contracted.

As to the question of antisepsis a man is largely guided by his experience, and we younger men are compelled to follow the opinions of our elders. I differ with Dr. Theobald on that question, but if what Drs. Knapp, Hotz and Thompson said about it did not convince him, I am sure I can do nothing. There is such a thing as a consciousness that you have not done the harm, if harm comes. The eye is less apt to receive infection than any other part of the body. Dr. Welch has spoken of the great difficulty of finding bacteria in the conjunctival sac. He stated that bacteria might be placed there and that cultures made in five minutes would show few and in fifteen minutes none. He gave, as the reason, their mechanical removal. This is all true, but cases do occur where, in spite of every precaution, trouble comes and infection occurs. The patient has a little pain, you find edema of the lids, etc., and you know what's up and there is a comfort in knowing that you did not cause it. My habit is to have the cocaine and atropia solutions sterilized

and my instruments boiled in a weak bicarbonate solution for five or ten minutes before the operation. I see that the lachrymal sac is clean, but use no anti-septics on the eye. After the operation I usually bandage the eyes with sterilized cotton and let alone for forty-eight hours. It is a singular thing that in that Baltimore hospital where isinglass plaster was first introduced it is now discarded. The reason was that we got into the habit of opening the eye inside of forty-eight or twenty-four hours to see if there was any hernia, the idea being to break up any adhesions that were present. We found the cotton easier to remove than the plaster, and when we came gradually back to the combined operation we simply did not again take up the plaster. Where the iridectomy is done I always use atropia immediately after the operation and I have never seen any harm result from it.

In reference to the position of the section I agree with Dr. Theobald that it is the best along the limbus. As to the section of the capsule I use the cross cut at the top. As to immature cataracts I think the tendency is now to operate earlier than formerly. I agree with Dr. Theobald, too, in his observation that the astigmatism is usually against the rule. It often amounts to from two to four diopters.

*Dr. A. K. Bond:* I would like to ask whether disease cannot travel up from the nose, through the tear duct into the eye, and if it would not be well to spray the nasal duct before eye operations. In a case of very mild purulent conjunctivitis of the newly born, I have seen reinfection of the conjunctival sac from the lachrymal sac or nose. It was probably not a case of gonorrhreal conjunctivitis.

*Dr. E. J. Bernstein:* My experience has not been large, but from watching the work of others, operating with or without iridectomy, it seems to me the weight of evidence is in favor of the combined operation. The only advantage of the simple extraction seems to be the round pupil and that, I think, is a very questionable one. I doubt if one person in a thousand would observe the

eye closely enough to tell whether its pupil was round or not. Dr. Knapp said that he got fifteen per cent. of prolapses even after he had selected his cases. You get no better sight and have to operate for secondary cataract more frequently. I want to ask Dr. Theobald whether he would refrain from operating in a case of cataract which was not ripe, but which gave great visual disturbance? Fuchs operated time and time again upon such cases.

*Dr. Herbert Harlan:* As all who have spoken are inclined to favor the operation with iridectomy I want now to state my case. I am on the other side. Dr. Theobald left out one point I consider important. In cases of fully mature cataracts there is a great deal of cortical matter that does not come out with the nucleus and is hard to get out when done without iridectomy. I think in regard to the improved appearance of the eye that it is a great advantage, and I think, too, that there is a gain in vision. I recall one patient operated upon the first time with iridectomy who got good vision. The other eye was operated upon without iridectomy and vision measured with the test types was the same as the first eye, yet she always felt that her vision in the second eye was better. I think also that the operation is an easier one, though it is usually spoken of as being more difficult. A large corneal section is not much more difficult to make than a small one. The iris is nearly always sensitive and when caught by the forceps and cut it is painful and the patient moves. The iridectomy, too, necessitates the aid of an assistant. In many cases the iris bleeds and it is difficult to get this blood out of the anterior chamber.

I grant that there are some hernias after the simple extraction. My recollection is that Knapp makes it 8 or 9 per cent., instead of 15 per cent., but when hernia occurs it is usually not to be disturbed as the eye is not destroyed at all. Some interesting statistics have been recently published from which it is made out that the results are better in those cases done without iridectomy. I use atropia before and after the opera-

tion and have practically no hernias. I prefer to keep both eyes closed for twenty-four hours, and I believe that if the section be made large, atropia used both before and after operating and the patient kept quiet, there is no reason why we should not do the simple extraction.

*Dr. R. L. Randolph:* I do not think one is justified in modifying antiseptic precautions in eye operations. The fact that Knapp failed to get infection in his tests does not prove that there were no organisms on the knife, but only that there were less of them. Rabbits are very much more resistant than human beings.

In doing any operation upon the eye I make it a rule to follow the same course as I would if operating upon the brain or belly. I put all of my instruments except the knife into boiling water, and place the knife into absolute alcohol until ready to use, when I dip it into boiling water. This method does not affect materially the sharpness of the blade.

I have been struck by the immunity of the eye from infection. Bach has shown that not only do tears possess a slight germicidal effect but also the intraocular fluids. They probably inhibit the organism and give the tissues time to heal, which is of course what is desired in these cases.

As regards the operation with or without iridectomy my experience is too limited to say much about the latter operation, but I am inclined to favor the simple extraction.

In 160 cataract extractions I have done 22 without iridectomy. In the first two I had prolapse, but I had used eserine. In the last 20 I used atropia and had no hernia.

*Dr. Samuel Theobald:* The inference might be drawn from Dr. Wood's remarks that I did not take antiseptic precautions in cataract operations. I do in all cases in which an incision is made into the eyeball. I have not taken the same precautions in external operations, such as tenotomies. I keep my instruments clean, of course, and so far have had no trouble. Suppurative

trouble after tenotomies is almost unheard of.

In regard to infection from the nose, that is possible but extremely unlikely to occur unless there is blenorhoea, which should, of course, be looked after. The point has been made that phlyctenular trouble may come from the nasal duct. Whether that view has a sufficient basis I do not know, but I am inclined to disregard it and consider such trouble as constitutional.

As to Dr. Bernstein's question, I would say that I would not hesitate to operate if the patient was already blind in the other eye. I have frequently done so, but I would not feel justified in doing so if one eye had good vision.

I have been interested in the testimony given as to the use of eserine or atropia, and have been not a little surprised. When we dilate the pupil and operate, the moment the aqueous escapes I should expect the pupil to begin to contract and should think prolapse would be more likely to occur. The facts as given by Drs. Randolph and Harlan seem to disprove that.

"A Case of Irido-Dialysis, with Operation," Dr. Hiram Woods. In the early part of October a farmer was sent to me, who had been hit in the eye by a man's fist bearing a ring upon one of the fingers. The only injury was the breaking away of the iris in its upper two-thirds from its attachment.

By the drooping iris the normal pupil was reduced to a small hole. Through either the upper or lower pupils he had  $\frac{2}{7}0$  vision and could read the "Sun" paper. A more exact test of vision was not made. Through the upper pupil the ciliary processes could be seen. The eye was practically useless to him on account of the string across the pupil. I thought of going in and trying to cut this thread. Dr. Chisolm suggested that I make an effort to replace the iris after the same method of irido-donesis operation to produce an artificial prolapse. I tried it and made the incision 2 mm. behind the corneo-scleral junction, with a spade knife, into the anterior chamber. The thread of iris slipped away from me, but I grasped it again

and pulled it out into the opening. The wound healed over it without any trouble and now, two weeks after the operation, the appearance is that of a widely dilated pupil. The lens is perfectly clear, his vision is  $\frac{2}{5}$  and he can still read fine print.

"A Case of Acute Endocarditis, with Remarks Upon the Management of Similar Cases," Dr. Charles O'Donovan.

The Society then adjourned.

H. O. REIK, M. D.,  
Secretary.

### MEDICAL PROGRESS.

**INTESTINAL ANASTOMOSIS.**—Dr. Augustus Schachner, in an elaborate article in *Mathews' Medical Quarterly* on modern method of intestinal anastomosis, says in conclusion:

1. The highest degree of vascularity in the intestine is in the region of its mesenteric border, and the lowest degree is at a point just opposite the mesenteric border.

2. The highest degree of vascularity in the stomach is along its curvatures, and the lowest degree is at a point midway between its curvatures. Throughout the entire intestinal tract there is an absence of the serous coat at the mesenteric border.

3. In view of the diminished vascularity and the constant presence of the serosa at a point midway between the curvatures in the stomach and opposite the mesenteric border in the intestines, these regions should be regarded as *the lines of safety*, and when permissible should always be given the preference in all operative measures.

4. The dangers of sepsis, hemorrhage, peritonitis and non-union increase in direct ratio as we recede from the lines of safety.

5. The strength of a continued or Glover's suture is measured practically by its weakest stitch; if this tears, the remaining stitches are all more or less loosened and the end nearly always defeated.

6. Barring certain exceptions the continued or Glover's stitch is the most

rapid, most uncertain, and most uneven stitch that can be applied.

7. No method of intestinal resection, however simple it may be, will receive full justice in the hands of even the most ingenious surgeon at its first performance. For this reason it should be the duty of all those expecting to engage in such work to thoroughly train themselves in intestinal operations in a practical way, either on lower animals or upon the dead subject.

8. The end-to-end method of restoring the continuity of the intestine in resections is attended with the least contraction and affords the most natural restoration of the intestinal canal.

9. The opening in all lateral anastomoses should be abundantly large (four inches) to allow for subsequent contraction, which always takes place to a considerable degree.

\* \*

**THE PHYSICIAN'S DUTY IN OBSTETRICAL CASES.**—Dr. Elliot T. Brady says, in the *Virginia Medical Monthly*, that the term "meddlesome midwifery" is a much abused one. He considers a constant amount of attention both before, during and after labor imperative and lays down the following rules :

1. By observation and palpation, satisfy yourself that the patient is actually in labor.

2. Ascertain if bowels and bladder are empty ; if not, empty them at once.

3. Make a digital and bimanual examination, and determine presentation and relative size of head and birth canal.

4. If abnormal or difficult presentation, try to correct it.

5. Examine at regular intervals ; if normal, to see that it stays so ; if abnormal, to improve presentation if possible, and in either instance to note progress.

6. If, from failure of contractions, after dilatation of os, from great size of head, small size of pelvis, or other causes, delay seems dangerous, apply forceps.

7. Protect perineum ; and if necessary, retard extra rapid second stage.

8. Never allow the head to be retained long after delivery of body, in breech-presentations.

9. Always examine placenta carefully, and if portions are, or even seem to be, detached, go after them at once. Observe absolute cleanliness throughout.

All will agree on these points. Individually, I approve of the use of chloroform to the degree of "obstetrical anesthesia" in all cases, and also the skillful use of forceps in all difficult or delayed labors.

\* \* \*

**A NEW STYPTIC.**—Dr. Roswell Park has called the attention in the *Medical News* to the advantages of a combination of antipyrine and tannic acid as a powerful and simple styptic. He came upon this combination accidentally in an emergency and finds it easily applied and very effective. When these two substances are brought together there is formed a gummy, sticky substance which may be applied on a sponge. The two may be combined in almost any proportion.

\* \* \*

**TRIONAL.**—Weiss of Vienna, in the *Medizinisch - Chirurgisches Centralblatt*, pays a high tribute to that new hypnotic, trional. He considers it superior to all the most approved sleep-producers and recommends its use in nervous affections, such as neurasthenic insomnia; chronic dementia, periodical mania, paralysis, melancholia and allied troubles. It is also useful in some forms of neuralgia, sciatica and tabes. Its effect is sometimes late, due to a cumulative action. It is best given in doses of fifteen to thirty grains in some hot fluid as soup and should be discontinued after four or five days. During its administration, alkaline water or bicarbonate of soda should be given. It is a comparatively safe hypnotic, having little or no toxic effect and no marked taste.

\* \* \*

**INFANTS' FOOD.**—Dr. B. Van D. Hedges, in the *New York Medical Journal*, discusses the quality and quantity of an infant's food and asks what treatment has it in health or disease to demand. The mother's milk should be given if possible. Nothing can improve on that when mother and child are both

healthy. Syphilis and tuberculosis are contra-indications. Poor breast milk may demand other sources of food. Cow's milk is the next best thing but it must be modified.

Dr. Meigs of Philadelphia has given the following formula :

Milk . . . . .	1 part.
Cream . . . . .	2 parts.
Lime water . . . . .	2 "
Sugar water (3 <i>i</i> to 3 <i>i</i> )	3 "

Milk laboratories in large cities do great good. Artificial foods amount to little. Condensed milk is a good substitute, cheap, easy to prepare and practically sterile. Peptonized foods were never intended for healthy infants. Many so-called predigested foods contain unconverted starch.

Many babies die from overfeeding. The size of the stomach bears a distinct ratio to the size and weight of the infant. Thus an infant having an initial weight of seven pounds would have a gastric capacity of a little over an ounce, while a child of twelve may have double that capacity. The average capacity for an average child under one month is between one and two ounces with a gain of one ounce a month to the sixth month. When a baby nurses it rarely takes too much. This scale should be used every week. A gain of a half to three-quarters of an ounce a day shows progress but less than that shows the child is losing ground.

We cannot improve on Nature's method of caring for the young.

\* \* \*

**ADENOID GROWTHS AND HEADACHES.**—Dr. Howard S. Straight reports, in the *Medical News*, a case of headache in a boy sixteen years old due to adenoid growths. He had suffered for three years. His eyes were in good condition, but he complained of catarrh. The headache would begin in the morning and last until noon. The growth was found. The soft palate and pharynx were painted with a 20 per cent. solution of cocaine and the growths well scraped out with a Gottstein curette. The headaches disappeared at once and have never returned.

## MARYLAND

## Medical Journal.

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BALTIMORE, DECEMBER 21, 1895.

NOTWITHSTANDING the fact that the infectious nature of pulmonary tuberculosis is now recognized by physicians all over the world, it is curious to note that steps have so far been taken by only one city to place this, the most prevalent disease of the present century, under sanitary control. The health authorities of New York certainly deserve the greatest credit for the standpoint taken by them, and it is to be hoped that their example will be followed at an early date by other municipalities. Proper sanitary laws in this respect can only then be obtained, however, if the medical profession rises to a man and declares that it will no longer permit the ravages of a disease, the infectious nature of which is generally recognized and the modes of prevention of which are definitively known.

From 1200 to 1500 valuable lives are yearly sacrificed under the present conditions in the city of Baltimore. Supposing that the same

number of deaths occurred from smallpox or cholera, the entire community would rise and rightly demand that the State and city health authorities take steps to prevent such frightful ravages at once. As it is, nothing is done.

Pulmonary consumption might be compared very properly to the old skeleton in the home of the physician. The children have become accustomed to its presence and no longer dread it. Modern writers delight in the hectic flush, the sentimental eye, the wasted form of the consumptive, and would undoubtedly be inconsolable if consumptive models could no longer be procured.

The Health Commissioner of Baltimore has urged upon the Mayor and City Council the necessity of placing cases of pulmonary tuberculosis under sanitary control, just as cases of diphtheria, scarlatina, typhoid fever, etc., again and again, with the usual result. There can be no excuse for this lack of activity on the part of the medical profession and of the health authorities in charge. Let it be hoped that every physician of standing, every medical institution and every medical society in the city and State will come forward now and promptly endorse the movement undertaken by the MARYLAND MEDICAL JOURNAL for the benefit of the city and State. A successful issue of this crusade will crown our attempt.

## The following is the New York Law:

The communicability of pulmonary tuberculosis has been so thoroughly established, and is now so generally recognized by the medical profession throughout the world, that the Board of Health of New York City has determined that the time has arrived when active steps should be taken looking toward its prevention in this city. The Board has therefore resolved to adopt the following preliminary measures:

1. The Department will hereafter register the name, address, sex, and age of every person suffering from tuberculosis in this city, so far as such information can be obtained, and respectfully requests that hereafter all physicians forward such information on the postal cards ordinarily employed for reporting cases of contagious disease. This information will be solely for the use of the Department, and in no case will visits be made to such persons by the inspectors of the Department, nor will the Department assume any sanitary surveillance of such patients, unless the person resides in a tenement house, boarding-house, or hotel, or unless the attending physician requests that an inspection of the premises be made; and in no case where the person resides in a tenement house, boarding-house or hotel, will any action be taken if the physician requests that no visits be made by inspectors, and

is willing himself to deliver circulars of information, or furnish such equivalent information, as is required to prevent the communication of the disease to others.

2. Where the Department obtains knowledge of the existence of cases of pulmonary tuberculosis residing in tenement houses, boarding-houses, or hotels (unless the case has been reported by a physician, and he requests that no visits be made) inspectors will visit the premises and family, will leave circulars of information, and instruct the person suffering from tuberculosis and the family as to the measures which should be taken to guard against the spread of the disease, and, if it is considered necessary, will make such recommendations for the cleansing or renovation of the apartment as may be required to render it free from infectious matter.

3. In all cases where it comes to the knowledge of the Department that premises which have been occupied by a tubercular patient have been vacated by death or removal, an inspector will visit the premises and direct the removal of infected articles, such as carpets, rugs, bedding, etc., for disinfection, and will make such written recommendations to the Board as to the cleansing and renovation of the apartment as may be required. An order embodying these recommendations will then be issued to the owner of the premises, and compliance with this order will be enforced. No other persons than those there residing at the time will be allowed to occupy such apartments until the order of the Board has been complied with. Infected articles, such as carpets, rugs, etc., will be removed by the Department, disinfected, and returned without charge to the owner.

4. For the prevention and treatment of pulmonary tuberculosis it becomes of vital importance that a positive diagnosis shall be made at the earliest possible moment, and that the value of bacteriological examinations of the sputa for this purpose may be at the service of physicians in all cases not under treatment in hospitals, the Department is prepared to make such bacteriological examinations for diagnosis, if samples of the sputa, freshly discharged, are furnished in clean, wide-necked, stoppered bottles, accompanied by the name, age, sex, and address of the patient, duration of the disease, and the name and address of the attending physician. Bottles for collecting such sputa, with blank forms to be filled in, can be obtained at any of the drug stores now used as stations for the distribution and collection of serum tubes for diphtheria cultures. After the sputum has been obtained, if the bottle, with the accompanying slip filled out, is left at any one of these stations, it will be collected by the Department, examined microscopically, and a report of the examination forwarded to the attending physician free of charge.

5. The authorities of all public institutions, such as hospitals, dispensaries, asylums, prisons, homes, etc., will be required to furnish to the Department the name, sex, age, occupation, and last address of every tubercular patient coming under observation within seven days of such time.

It is the earnest wish of the Board of Health that all practicing physicians in this city coöperate with the Board in an earnest and determined effort

to restrict the ravages of this the most prevalent and formidable disease with which we have to deal.

The following questions have been sent to every physician of Baltimore :

Admitting the infectious nature of tuberculosis :— 1. Do you favor the enactment of a law placing this disease under the control of the Health Authorities of the State and City of Baltimore? 2. What are your views regarding the New York Law (of which we enclose a copy) concerning the same subject? 3. Would you suggest the enactment of the same law in the State of Maryland and in the City of Baltimore, or would you offer any amendment to the same? 4. Do you favor the establishment of a Municipal or State Institution, to be devoted exclusively to the treatment of pulmonary tuberculosis? 5. Admitting that a diagnosis of the disease in its early stages can frequently be effected only upon the basis of a microscopic examination of the sputa, do you favor the establishment of a municipal bacteriological laboratory in which sputa shall be examined for physicians free of charge?

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AS STATED in these columns three weeks ago, the fate of the *Index Medicus* has been decided and the journal will *Index Medicus*. be republished, the two hundred and two names having been subscribed. The work ceased to appear last April, and the editors will take it up from that date and cover all the literature as rapidly as possible. Reports state that it is to be a monthly and not a quarterly as was first suggested.

One exchange doubts the propriety of limiting the output to 202 copies and suggests that if more wish to subscribe to let them do it. Such a plan seems to be in the line of business and even if the first subscriber deserves the honor of encouraging a good move, the last humble petitioner with his twenty-five dollars should not be shut out.

The work is a success now and the uncertain members of the profession who always wait like sheep to follow the lead of greater minds might be allowed in this case to straggle in as long as the money is put up. It may be that next year some of the original 202 will drop out or some new development will be suggested, entailing greater expense, and then these last subscribers and their money will be welcome.

**MEDICAL ITEMS.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending December 14, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		24
Phthisis Pulmonalis.....		15
Measles.....	136	5
Whooping Cough.....	2	
Pseudo-membranous {	29	19
Croup and Diphtheria.		
Mumps.....	2	
Scarlet fever.....	23	1
Varioloid.....		
Varicella.....	1	
Typhoid fever.....	3	

The Pennsylvania State Medical Board held a meeting last Tuesday at Philadelphia.

It is said that the women of England smoke tea in the form of cigarettes instead of drinking it.

A judge has decided at Battle Creek, Michigan, that a physician must testify in regard to the ailments of his patients.

The Providence Hospital of Baltimore, which is managed by colored people, will be enlarged at an expense of \$2000.

The London Hospital, through the liberality of a patient of Mr. Treves, is soon to have a portrait of that celebrated surgeon.

At the meeting of the University Medical Society held at the University of Maryland last Tuesday night it was decided to issue a "Hospital Bulletin."

The French Government does not allow the sale of serums and other such products until they have received official sanction, granted only after an examination by a committee of the Academy of Medicine.

Dr. Canini of Leghorn, the specialist on diseases of children, who died a short time ago, has bequeathed his entire estate, amounting to \$460,000, for the establishment and maintenance of a children's hospital devoted to the serum treatment of diphtheria.

Experiments upon the criminals in the jails of Punjab, India, have been ordered by the Governor. Half of the prisoners are to be kept on raw water and half on boiled

water, the object being to learn whether the cooked water possesses any influence calculated to prevent disease.

The *American Medical Review* is a new monthly modeled after *The Review of Reviews*. It is very full, yet concise, and the editing gives evidence of much care and labor. Dr. Daniel Lewis is editor and the R. N. Plummer Co., publishers.

Dr. William Compton, one of the oldest physicians of Lancaster, Pa., died at his home last Sunday after a brief illness of pneumonia. Dr. Compton was a member of the American Medical Association and local societies and held at various times important positions.

The City of Paris has decreed that the diagnosis of all diseases due to known micro-organisms shall henceforth be undertaken at the bacteriological laboratory of the city, and that any practitioner can send his specimens there and have the examinations made gratis.

Professor R. Dorsey Coale has succeeded the late Dr. J. Edwin Michael as dean of the University of Maryland Medical School. Dr. Charles W. Mitchell has been lecturing on Obstetrics during the whole of Dr. Michael's illness and will hold the chair until a new Professor of Obstetrics has been elected.

At a special meeting of the Executive Committee of the Princeton Alumni Association of Maryland, held December 9, 1895, the following was adopted:

"The members of the Executive Committee of the Princeton Alumni Association of Maryland have learned with deep sorrow of the death of Dr. J. Edwin Michael, ex-President of this Association and member of the Executive Committee. In his death we recognize the loss to the community of a skillful, conscientious surgeon; to the Medical School with which he was connected, a painstaking, instructive teacher; to our Alma Mater, an alumnus devoted to her interests and one gratefully acknowledging his indebtedness to her, while our relations during recent years in the Association's work have endeared him to each of us as a personal friend.

*Resolved*, That this minute be spread upon the Association's records, published in the Baltimore *Sun*, MARYLAND MEDICAL JOURNAL and the *Princetonian*, and a copy be sent to Dr. Michael's family. (Signed) John P. Poe, President; George R. Gaither, Jr., Treasurer; Wm. L. Hodge, Secretary, H. P. C. Wilson, Henry D. Loney, E. J. D. Cross, Hiram Woods, Jr., Richard K. Cross, Wm. W. Cator, Executive Committee of the Princeton Alumni Association of Maryland.

## WASHINGTON NOTES.

The Medical Society of the District of Columbia held its regular weekly meeting on Wednesday evening, December 11, the President, Dr. Samuel C. Busey, in the chair. Dr. Swan M. Burnett presented a Case and Specimen of "Intra-Cranial Tumor." Dr. E. Oliver Belt reported a "Case of Skin-grafting for Ectropion"—patient presented. Dr. Samuel S. Adams reported a Case and presented the Specimen of "Ulcerative Endocarditis." Discussed by Drs. Walter Reed, W. W. Johnston and D. S. Lamb. Dr. H. L. E. Johnson reported Cases and Specimens of "Seven Laparotomies." Dr. J. Wesley Bovée presented specimens of "Polypus from the Uterus, Pus Tubes and Nephrectomy."

Dr. Ernest La Place of the Medico-Chirurgical College of Philadelphia is giving a short course of lectures on Brain Surgery at the Georgetown Medical College.

Dr. Charles M. Emmons has been appointed Physician to the Poor, also other appointments as Physicians to the Poor have been made as follows: Dr. D. G. Lewis, vice Dr. H. S. Goodall, Dr. F. O. Roman, vice Dr. C. V. Petteys, and Dr. G. W. Wood, vice Dr. C. W. Birdsall.

The Alumni Association of the Columbian University held its annual meeting on Friday night, December 13, for the election of officers. Dr. C. W. Richardson was unanimously chosen President. A bountiful collation was spread in an adjoining room.

The Board of Directors of the Central Dispensary and Emergency Hospital held its regular meeting on December 13.

Dr. George M. Sternberg, Surgeon-General United States Army, as retiring President of the Biological Society of Washington, delivered an interesting address at Builders' Exchange Hall, entitled "The Practical Results of Bacteriological Researches." Lantern slides were used to illustrate the many phases of bacterial life.

The Health Officer's Report shows that the death list last week was considerably below the normal, a decline of nearly 20 per cent., as compared with the week before. Mortality of consumption fell from 17 to 7 and acute lung trouble from 26 to 11 and only two deaths from typhoid fever. The contagious diseases show no tendency to assume epidemic form. Of the fatal cases of diphtheria reported, 2 were attended with serious complications.

## PUBLIC SERVICE.

## UNITED STATES ARMY.

*Week ending December 16, 1895.*

Captain William P. Kendall, Assistant Surgeon, upon the expiration of his present leave of absence is ordered to Fort Sam Houston, Texas, for duty.

First Lieutenant John S. Kulp, Assistant Surgeon, will upon the expiration of his present leave of absence be relieved from duty at Fort Spokane, Washington, and ordered to Fort Walla Walla, Washington, for duty.

The leave of absence granted Captain William B. Banister, Assistant Surgeon, is extended one month.

The leave of absence granted First Lieutenant James M. Kennedy, Assistant Surgeon, is extended two months.

Captain Charles E. Woodruff, Assistant Surgeon, now on leave of absence, is ordered to proceed from Washington, D. C., to Fort Snelling, Minn., and report for temporary duty without delay.

Major Richard S. Vickery, Surgeon, is retired from active service this date, December 7, 1895.

Captain Freeman V. Walker, Assistant Surgeon, is by direction of the President, wholly retired from the service this date, December 4, 1895.

## UNITED STATES NAVY.

*For One Week ending December 14, 1895.*

Passed Assistant Surgeon G. T. Smith, United States Navy, detached from the "Ranger" and ordered to the "Adams."

Assistant Surgeon M. K. Johnson ordered to the Naval Laboratory and Department of Instruction, New York.

## BOOK REVIEWS.

**MATERIA MEDICA AND THERAPEUTICS.** A Practical Treatise with Especial Reference to the clinical application of drugs. By John V. Shoemaker, A. M., M. D., LL. D., Professor of Materia Medica, Pharmacology, Therapeutics and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical Hospital, Philadelphia; Physician to the Medico-Chirurgical Hospital, Philadelphia, etc. Third edition, thoroughly revised. Reset with New Type and Printed from New Electrotypes Plates. Royal Octavo, Pages IX, 1108. Extra Cloth, \$5.00 net; Sheep, \$5.75 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

It is with pleasure that we recommend Dr. John V. Shoemaker's third edition to the medical student not only, but to the entire profession. The work now appears in one

instead of two volumes, which is undoubtedly a great improvement. The general arrangement is excellent and the subject-matter up to date. It is very gratifying to note that the author has devoted 241 pages of his work to the non-medicinal treatment of disease, including electro-therapeutics, mechano-therapy, massage, pneumotherapy, hydrotherapy, balneotherapy, climatotherapy, dietetics, hypnotism, etc. We should suggest that in a future edition the table of doses, the general index and the clinical index be printed in larger type.

**OUTLINES OF MATERIA MEDICA AND PHARMACOLOGY.** By H. M. Bracken, M. D. P. Blakiston, Son and Co. 1895. 8vo. Pages 383.

The author states in his preface that the book is the outgrowth of work arranged in 1893 for medical students at the University of Minnesota, under the title of "Outlines of Materia Medica." It is intended to serve the purpose of a text-book for use in the study of Materia Medica, to facilitate note-taking in the lecture room and to aid in the laboratory study of drugs.

It is hardly likely that the volume will be of much value to medical students in general, while it may be of use to the author's own pupils. It would have been better to omit the word "Pharmacology" from the title, as the book really contains but a meager outline of the action of drugs. The author's style, as well as his Latin, are frequently objectionable; "per orem" is distressing. In view of the fact that other and excellent works exist upon the subject, it is not altogether clear why the volume has been written.

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#### REPRINTS, ETC., RECEIVED.

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Synopsis of One Hundred Ovariotomies. By Edward Borck, A. M., M. D., of St. Louis. Reprint from the *Medical Mirror*.

The Operative Treatment of Fistula in Ano. By Lewis H. Adler, Jr., M. D. Reprint from the *International Medical Magazine*.

Two Abscesses of the Brain. By J. T. Eskridge, M. D., and Clayton Parkhill, M. D., Denver. Reprint from the *New York Medical Journal*.

Address on the Founding of the Illinois Hospital. By S. S. Bishop, M. D. Reprint from the *Journal of the American Medical Association*.

#### CURRENT EDITORIAL COMMENT.

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##### OVERDONE STERILIZATION.

*The Journal.*

THERE is a golden mean in all things and even the most salutary and sanitary practices can be carried to excess. In what may be termed microbophobia, the extremes of caution as to the exposure to pathologic germs, there may be a danger on the other side; one may, in avoiding the Scylla of organic infection, fall into the Charybdis of chemical poisoning, or starvation.

##### DISPENSARY ABUSE.

*Cincinnati Lancet-Clinic.*

THE dispensary sign is a temptation to the avaricious, who are more or less abundantly able to pay in cash for medical services and for medicines. This evil is not confined to the imposition practiced upon the medical college faculty, but extends, and is much greater in the severity of its effects, upon the legitimate work of the whole local medical profession. This pertains particularly to the young men of the profession. These physicians have spent years of time and paid into the colleges large sums of money, and now that they are declared to be qualified practitioners it is found that the field in which they expected to become industrious gleaners is raked over and over again by the college harvester for dispensary clinic material.

##### MEDICAL SKEPTICISM.

*Southern California Practitioner.*

REMEDIES for medical skepticism may be found in the avoidance of haste on the part of competent observers in announcing discoveries; the acceptance of such announcements by the profession as final, only after authentic confirmation by other observers equally proficient; in an intimate acquaintance with post-mortem pathological conditions; in a constant and careful clinical study of selected cases; in an individual reduction of the *materia medica* to a practical working basis, making possible a thorough acquaintance with every action of the remedies used; and lastly by the maintenance of a readiness to recognize and admit one's fallibility, and the possibility of learning something worth knowing from somebody that knows less than he does.

# MARYLAND

# MEDICAL JOURNAL

A Weekly Journal of Medicine and Surgery.

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## ORIGINAL ARTICLES.

### TYPHOID FEVER.

By Edward Anderson, M. D.,  
Rockville, Md.

THE above entitled subject has occupied a great part of my time and attention for the last twenty years. The fact that it has destroyed more young adult lives in our county than all other acute diseases lends additional interest to an otherwise interesting subject. Immunity from disease is occupying the attention both of the bacteriologist and general practitioner to a greater extent than any other subject.

Immunity from typhoid fever is of more importance than from any other disease except smallpox, for when once secured as by an attack, it obtains for life. That partial immunity from typhoid is obtained by a residence in a city or a malarial district I do not think admits of a doubt, for such persons coming into country towns during the typhoid season (and there are many who do) rarely contract the disease, while a young adult from the surrounding country is almost sure to be stricken down during his first season in town.

I quote the following from the Medical and Surgical History of the War between the States, prepared by Dr. Charles Smart of the United States Army: "The United States Army of the Potomac was largely recruited from the urban population of the New England and other Eastern States. In its ranks there was certainly a larger proportion of city men than in the Southern

Army. This appears to have a bearing on the greater frequency of typhoid fever in the latter in view of the well known facts that a majority of the enteric cases in cities occur in young people recently from country districts and that an army encampment is, in many of its sanitary relations, an extemporized city."

I will now quote from an article read at the forty-fourth annual meeting of the American Medical Association, by Dr. James B. Herrick of Chicago: "I regret my inability to furnish exact figures as to the proportion of cases among new-comers to Chicago. In private practice twenty-six per cent. of my patients with typhoid fever had been in the city less than one year. I am confident that in the County Hospital where foreigners make up a goodly percentage of the inmates, thirty or forty out of every one hundred typhoids were new-comers. The large influx of population to Chicago for the past few years, the new-comer not possessing immunity against typhoid infection may explain in a measure the fearful prevalence of this disease during the past five or six years. It has seemed to me that the new resident has been especially liable to a severe form of the disease."

Now as to the etiology of typhoid fever, the most important point, it is utterly useless to attempt to study the origin of this disease in a city, the coun-

try being the only place where such research could avail, for there, as far as typhoid fever is concerned, each man is responsible for the health of his family. There is no doubt in my mind, nor will there be in the mind of anyone who investigates the matter in the right way, that typhoid fever results from the rapid drying of earth near our dwellings. Let that earth be covered with water for any length of time and dry out slowly, malarial fever is the result; drain it and we have typhoid; cover it with sod or asphalt and we will have neither. Both diseases are of the earth, earthy.

In refutation of the theory that water is the cause of typhoid fever, I annex the following from the pen of Dr. Lewis N. Davis of Farmland, Indiana, read at the forty-fourth annual meeting of the American Medical Association: "The drinking water is obtained from wells which are usually about twenty feet in depth. The first ten feet traversed in sinking a well are through the heavy yellow clay just spoken of, thence to a stratum of sand where an abundance of water is obtained through a very dense, sticky, blue clay. Both kinds of these clays are almost impervious to water, so that percolation of surface water into the wells might be regarded as practically nil. It can only be in the rarest possible instances from wanton carelessness that surface water finds entrance directly into a well through slight depressions or fissures in the ground. The wells are usually thoroughly protected against surface water by embankments and the whole arable country is well drained with a perfect system of tiling. The farmers are well-to-do and are usually tidy about their premises.

As respects their sanitary surroundings they are quite abreast with the average of their class in the best agricultural sections of any country.

But a little more than two generations have passed since the white man first broke the soil. The history of the early settlers affords but very few well authenticated cases of typhoid fever. The great scourge of the Hoosier from the time the first forest trees were felled

until the year 1879 was malarial poison. Malaria in its multifarious forms prevailed from August till December. For the past twelve years, from some unknown cause, malarial fevers have been superseded by typhoid.

The unknown cause was drainage. My county, with the exception of this year and last, when the drought was too protracted for the development of the disease, has furnished hundreds of cases of typhoid every year and nearly all between the first of June and the first of December, yet we drink the same water in the winter and spring that we use in the summer and fall. Facts are what we want, not theories. According to Peter Pinder, Sir Joseph Banks contended that fleas were of the same species as lobsters and to prove his theory boiled them. When they failed to turn red he exclaimed, "Fleas are not lobsters, d—m their souls." We have boiled the water that our typhoid patients drank for months previous to their illness, with the same negative result.

As long as Washington continues to be the large village that it is, the city of magnificent distances, with its large area of exposed earth, it will pay the penalty in the prevalence of typhoid fever. We pay too little attention to dieting in disease. Milk is the only reliable and suitable food for typhoid patients and by mixing dextrine and maltose with it, it is robbed of every objectionable feature and those fed upon it have a temperature one or two degrees lower than when fed upon milk alone. Persons suffering from this disease should be fed just as infants are that are suffering from bowel disorders incident to hot weather.

Last August, on account of the partial drying up of an artificial lake in this vicinity, three severe cases of malarial fever developed. On being called to the first case and finding the symptoms identical with those of typhoid and never having seen a case of malarial fever in this neighborhood, I treated it as I do my typhoid cases, by dieting alone, giving nothing but milk mixed with cooked starch. At my next visit to my surprise he had no fever and I

knew it was not a case of typhoid fever and told them I would come no more. The fever in every malarial case I have had since has disappeared on putting the patient on typhoid diet and returned on taking solid food too soon. From this year's experience I am led to believe that malarial fever can always be distinguished from typhoid by this procedure alone.

As to the production of typhoid fever from drinking well-water. Dr. Kober, I think, on investigating five hundred cases of the disease, found two hundred and eighty-three among those who drank well-water. That is exactly as one would suppose, for the wells are for

the most part in the outlying portions of Washington, when typhoid fever would occur if no water was drunk. Rockville and vicinity are supplied with water entirely from wells, two-thirds of which have been dry for months and many of those that are used will not yield over ten bucketsful in twenty-four hours. The best of our privies have tubs made by sawing coal oil barrels in two to catch the fecal matter, but in many of them it is allowed to fall on the ground and carted away every month, yet not a single case of typhoid fever has originated in the county, to my knowledge, since August.

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## APPENDICITIS.

READ BEFORE THE TRI-STATE MEDICAL ASSOCIATION OF WESTERN MARYLAND,  
WESTERN PENNSYLVANIA AND WEST VIRGINIA, AT CUMBERLAND, MD.,  
DECEMBER 12, 1895.

By C. C. Jacobs, M. D.,  
Frostburg, Md.

MR. PRESIDENT and gentlemen of the Tri-State Medical Society; I hasten to state that I have no long list of operated cases to report, nor newly devised technique for the performance of appendicectomy to lay before you. What I shall have to say on the subject of appendicitis will be general and very brief. I may venture the hope, however, that what may be lacking in my remarks will be well made up in the discussion by those present to whom a task like mine would have more fitly fallen.

Reginald Fitz of Boston first called attention to the frequency and importance of appendicitis in 1886. To the persistent and careful researches of Stimson, McBurney, Bull, Keen, Weir, Richardson and scores of others, equally capable and painstaking, is due the credit of perfecting the technique of appendicectomy, an operation which in the last five years has probably saved more lives than any other surgical procedure. Indeed the surgical treatment of appendicitis constitutes the most brilliant page in the history of modern surgery.

It will be observed, from the list of names above quoted and referred to, that the surgical treatment of appendicitis is of distinctly American origin. Strange as it may seem, European surgeons are slow to accept the teachings promulgated in this country. Within the last few months we read in the published discussion of a paper on the treatment of appendicitis, read by M. Milliard before a medical and surgical society in France, that there was a consensus of opinion in favor of the medical treatment of this disease to the almost exclusion of surgical measures and recommending the free use of opium as a means of immobilization. The other speakers differed from this more or less, and believe that while operation should not be undertaken in all cases, it was absolutely necessary in a certain number of instances. Surgical treatment was indicated : 1. In generalized peritonitis from perforation. 2. In perforative peritonitis having an acute course. 3. In which the purulent collection had reached a certain volume. 4. In recur-

ring cases of appendicitis. It was believed by four of the speakers that time should be allowed for the formation of protecting adhesions, which prevent the entrance of pus into the peritoneal cavity. M. Rendu believed that medical treatment should be begun at once, and the surgeon should not be called in at the first appearance of peritoneal symptoms, but only when a purulent encysted collection is definitely ascertained to be present.

Comment upon the foregoing rules, as formulated by French surgeons for the treatment of appendicitis, would be foreign to the object of this paper. They are quoted only to show the illogical and dangerous ground occupied by French surgeons on this important subject.

As to the management of this disease, statistics are not lacking to show, beyond question, that the method established and promulgated by the surgeons of this country is sound, and current literature teems with results that show but little more to be desired; many surgeons exhibiting a death rate of not more than one or two per cent.

What is wanting in this country is for the mass of the profession to realize the importance of the role they play in reference to the treatment of this fatal disease and especially the relationship that must exist between physician and surgeon, before the labor of the surgeon shall gain its full fruition, and everyone in this broad land of ours, if not in other lands, comes to realize that a disease, which a decade ago was so much to be dreaded and which numbered its victims by scores, has been robbed of its terror.

Notwithstanding the vast amount of literature on the subject of appendicitis, there is a very considerable proportion of the profession who today maintain that its treatment belongs purely within the province of the physician and believe they have cured by medical means every case of appendicitis they have been called upon to treat. With this belief it is no wonder they laugh to ridicule the great importance that has been ascribed to the disease by surgeons. It

is asked, "Why do those practitioners see no fatal cases of appendicitis?" The answer is that the mild or so-called catarrhal cases do recover under judicious medical treatment. In the more severe or septic cases, infection in a short time usually spreads and invades the peritoneum and the symptoms then constitute what was once known as idiopathic peritonitis and is still so regarded and called by those who claim that appendicitis is a disease of but little consequence, not comprehending that their cases of idiopathic peritonitis, which of course prove fatal, are cases of appendicitis such as the surgeon saves from a fatal termination by timely surgical measures.

It is high time that such notions as to the etiology of general peritonitis be discarded; for it is a well established fact that nearly all cases of general peritonitis except those that originate from the internal genito-urinary tract or follow operation have their origin in a septic inflammation of the vermiform appendix.

Long years ago, doctors discoursed with one another and with the laity about their cases of dropsy, ignoring the lesion of kidney, heart and liver. At the present day, no well-informed physician speaks of dropsy as a disease, but merely as a result of some diseased organ, and so treats the organ, not the dropsy. The same relationship exists between appendicitis and general peritonitis. It has also been amply demonstrated that appendicectomy, when done early, is attended with but trifling danger, but when done late or after adhesions have formed, or the infection has invaded the general peritoneum, the operation, often extremely difficult, usually fails to save the patient. Furthermore, many cases of appendicitis are attended with symptoms so mild as to cause little or no anxiety in the mind of the inexperienced attendant until suddenly and without warning, the patient goes into collapse and dies from the bursting of an encysted abscess into the peritoneal cavity or the rapid spread of infective germs.

A case recently operated upon by the

writer, on the twelfth day of the attack, and which made a good recovery, at no time had a pulse over 84 or a temperature above  $100\frac{1}{2}$ ° F. and after the first twelve hours complained of no pain, craved food and slept well every night. There was, of course, always tenderness, not acute, on pressure over the usual location of the appendix, at which point some swelling existed. The operation revealed a gangrenous appendix in a cavity containing about four ounces of pus. The patient was up in two weeks. The operation should have been done on the second day instead of on the twelfth, though our French colleague does advise waiting until protecting adhesions form.

As has been so often stated, there is no sign or symptom in the course of the disease which serves to indicate the time for operation. It appears that this question has been the subject of too much discussion and consequently the source of much unnecessary confusion among the mass of the profession. The gynecologist hesitates, not as to his course of treatment, when once he is satisfied that he has to deal with a pyosalpinx or any purulent collection within the pelvic or abdominal cavity, and when in doubt as to diagnosis unhesitatingly makes an explorative incision for the purpose of information on this point. Therefore, having ascertained that in a given case there exists septic disease of the vermiciform appendix, a disease demanding more decisive and prompt action on the part of the attendant, immediate operation is not only justifiable, but demanded in the interest of the patient, regardless of the presence or absence of any particular symptoms or set of symptoms tending to show that without operation the disease must rapidly end fatally.

Furthermore, when in doubt in certain cases, an explorative incision is not more dangerous and is more urgently demanded in view of the more imminent danger and rapid course of appendicitis, than in the case of suspected pyosalpinx. This plan, which is certainly the only rational and safe one, clears up all doubt as to the time for surgical treatment and

disposes of the danger and confusion caused by the effort to discover any certain symptom or sign to indicate that without immediate operation the patient must rapidly and surely perish. In view of the fact that by far the greater number of cases of appendicitis are first seen by the physician, and knowing, as we do, the rapid development of general septic peritonitis, in which case the surgeon is seldom able to save the patient, a great responsibility rests upon the physician.

However, but one line of action is open and his duty is clear, and we marvel that the mass of physicians has been so slow to see it, for it affords safety to the patient and peace of mind to the physician, viz., on first making a diagnosis of appendicitis, or even suspecting its existence, no matter how mild the symptoms, to summon a surgeon, and that without a moment's delay, to co-operate with him in the management of the case. This being done, the patient's condition should be constantly and intermittently watched. The symptoms not being severe and not increasing in severity, the operation may be deferred twenty-four or even forty-eight hours; during which time, there being no marked amelioration pointing unmistakably to resolution, immediate operation is demanded.

It will be seen that the symptoms demanding operation are negative, *i. e.*, the signs so anxiously looked for by the surgeon for guidance should be those of resolution, and not of dissolution. When the physician and surgeon of this country come to occupy a common ground as to the treatment of appendicitis, the mortality list will disappear from the tables of the statistician and modern surgery will have achieved its greatest triumph.

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UNCONTROLLABLE VOMITING OF PREGNANCY.—Benefin (*British Medical Journal*) has successfully treated uncontrollable vomiting in pregnancy by faradization of the vagi before or after meals.

## ANTISEPSIS.

READ BEFORE THE TRI-STATE MEDICAL ASSOCIATION OF WESTERN MARYLAND,  
WESTERN PENNSYLVANIA AND WEST VIRGINIA, AT CUMBERLAND, MD.,  
DECEMBER 12, 1895.

By *J. M. Spear, M. D.*,  
Cumberland, Md.

I CONCEIVE that the three most important subjects for the railroad surgeon's consideration are, named in the order of their importance, hemorrhage, shock and antisepsis. As the second mentioned subject has been ably discussed at this meeting, and the first mentioned, incidentally, in connection with the subject of shock, I have concluded to make the third the subject of this paper.

While I have admitted that antisepsis occupies third place in importance, I do so under protest and on the grounds that hemorrhage and shock require more activity and energy to avert an impending danger, but, after all, I believe that more deaths occur from a disregard of the principles of antisepsis than would result from all cases of hemorrhage and shock together, though they were left wholly untreated.

As a further excuse for, and as further extenuating circumstances for the crime of offering a paper on so anemic a subject, a subject so well understood and so largely discussed as antisepsis, I must say that I fear many railroad surgeons attach too little importance to its principles, or are careless as to the proper execution of them.

Schwann, in sowing the seed of the germ theory, in the year 1837, made it possible to construct the magnificent superstructure of antisepsis, which has since been built upon that foundation, and it is well for us to ever bear in mind that every detail of antisepsis has for its object the destruction of germs and that asepsis has for its object the protection of the tissues from inoculation with germs.

Long before the recognition of the germ theory we used creosote as a preservative of meats, we used heat as a

preservative of fruits, etc., and we used quinine and mercury for their known curative effects in certain diseases, without the knowledge that they all acted as germicides; but now, under the searchlight of modern science, we understand their modus operandi, which enables us to apply these and a large number of their rivals more scientifically.

Since carbolic acid volunteered its services, twenty-five or thirty years ago, the ranks of the antiseptic army has greatly swelled and has marched through the medical and surgical field fighting its battles with death and disease, holding the citadel against the pathogenic onslaught until many diseases have almost or quite disappeared from the face of the earth. Hospital gangrene, once the bane of the surgeon, has entirely disappeared, puerperal fever has practically become a disease of the past, the mortality being from all cases of sepsis in four of the largest maternity hospitals in New York City, computed on over four thousand cases, less than one eighth of one per cent., whereas, previous to the introduction of antiseptic precautions in 1883 by Dr. Garrigues, the mortality varied at different periods from five to twenty per cent.

But it is in the field of general surgery that antisepsis finds the widest application. There, too, it has contributed wonderfully to progress. Previous to the last thirty years (antedating the advent of antiseptics) opening one of the large cavities of the trunk or a wound penetrating the brain was looked upon as being almost necessarily fatal, and the opening of a joint was regarded as certainly fatal to the integrity and usefulness of that joint; but now we enter these cavities with impunity and

count on perfect motion in the latter cases. So lightly is an exploratory operation of the abdominal cavity regarded by some specialists, that I have heard one say that the operation was no more dangerous than vaccination.

Our experience under the antiseptic régime emboldens us to undertake, successfully, too, operations that the older surgeons would regard as impossibilities. All the different processes of grafting with skin, sponge, muscle, bone, cornea, etc., are only made possible through the educational influence incidental to the introduction of the antiseptic procedure. In the present state of our knowledge it becomes our duty in all cases of fracture of the skull with depression, penetration, hemorrhage, or symptoms of compression, to trephine, elevate, clean and antisepticize, and in all cases of penetration of the larger cavities or severe injury to viscera without penetration it is our duty to enter these cavities, arrest hemorrhage, remove foreign substances, stitch up rents, clean and sterilize in order that the patient may have the best possible chance for his life.

In fractures where the bones cannot be coapted or cannot be maintained in coaptation, it is allowable and proper, under antiseptic precautions, to cut down upon, approximate and retain, by wiring or other mechanical means, the separated fragments. This applies with particular force to fracture of the patella where, although such a process involves the joint, nothing short of drilling and wiring together the fragments promise the best results. It is questionable whether we should not in all cases of fracture or dislocation of the spine, when other means fail to reduce it, cut down upon the injury, remove spiculae of bone and adjust by sight. This operation, I believe, has been successfully performed by at least one member of our society. Why should it not be tried in all such cases, for can you be summoned to a more hopeless condition than a man with an injury involving displacement of the vertebrae, causing complete paralysis of the parts below? Do you ever feel more helpless in any case?

The suturing together of muscles, ligaments, nerves, and even vessels, have become practical operations, and quite recently an operator has sutured the tendon of one mobile muscle to the tendon of a paralyzed muscle in order to make it do vicarious duty. Such progress is due largely to the beneficent results of antisepsis.

The strict application of Lister's discovery to railroad surgery is the greatest element of conservatism. The lives saved and the functions preserved to parts by it that would have been sacrificed under the old septic treatment cannot be estimated. Neither can the time saved to the employee, as well as to the surgeon, and the money saved to the company by the shorter duration of the benefit period be calculated, to say nothing of the suffering and inconvenience to the patient and his friends.

It is not necessary to add words to what has already been said to prove to this association the benefits and advantages of antisepsis, but it would be time better spent in inquiring how we are to make antisepsis practical in railroad surgery. We must acknowledge that the railroad surgeon labors under great disadvantages. He often has to give the first aid in an open field or may have to perform an important operation in a dirty warehouse, caboose or watchbox. The parts to be treated surgically are always dirty and usually greasy, and the surgeon may find himself limited in other accommodations and appliances without proper assistance.

Under such circumstances the surgeon is apt to excuse himself upon these grounds if he fails to get an aseptic result. It may not always be possible to get the much-desired condition, but with the exercise of good judgment and great painstaking we may generally succeed, and I shall devote the remainder of this paper to a consideration of the means to be employed to reach this coveted goal.

Although the technique of antiseptic surgery, as treated by some authorities, seems quite complicated, it is capable of being reduced to a very simple procedure; and, although there are scores of chemicals employed, one of a selection

of three or four of them will be found sufficient to meet any emergency. With iodoform, boracic acid, bichloride of mercury and carbolic acid there is scarcely anything to be desired, unless you class the cleansing agents, such as water, soap, alcohol, ether, etc., along with them. The surgeon should not only be impressed with the idea that cleanliness is godliness, but that it is good surgery and without it we cannot have tolerable surgery.

Cleanliness is cheap, too. Any surgeon can have clean hands, clean instruments and a fair supply of antiseptic dressings with him for all emergency cases. He should have his kit packed and ready to start at a moment's warning. The receptacle need not be fine or expensive. That which I use myself is a cheap canvas telescopic traveling valise. It has the advantage of adapting itself to the bulk of material it is desired to encase. It should contain anesthetics, anodynes, antiseptics, stimulants, instruments, nested enameled pans, towels, ligatures, sutures, bandages and other dressing material, all sterilized, and, what I consider very important, two large bottles, one containing sterile water and the other a standard solution of bichloride of mercury, for you will often be so situated that you cannot procure sterile or even pure water. A few tooth powder or pepper boxes for your antiseptic powders are better than some of the more expensive, and a few feet of half-inch rubber tubing makes the best tourniquets. It matters but little as to the size and weight of your package, within certain limits, because you are generally conveyed to the scene of disaster by rail. So equipped one may feel himself pretty well prepared for any case that is likely to fall to his care, but of course where practicable all serious cases should be removed to a hospital.

The large majority of railroad cases require what might be called only routine surgical treatment. Something like this: The arrest of hemorrhage by simple means, if possible; cleanse the wounds and surrounding parts by washing with water and soap (if necessary to

remove grease with kerosene, alcohol or ether) and then with a bichloride solution; perform any necessary operation; again wash with an antiseptic solution and proceed to dress by dusting the parts with iodoform or boracic acid or a mixture of the two; apply aseptic gauze, cotton and bandage. If you have succeeded in suppressing all hemorrhage, rendered aseptic the parts and have used aseptic absorbable ligatures and sutures this is the only dressing that is likely to be required during the whole process of healing.

My rule for after-treatment following amputations or lacerations is to dress the wound as above indicated, and I seldom find it necessary to disturb it for two or three weeks, at the expiration of which time I usually find it well healed. Of course, general symptoms or hemorrhage may indicate that something has gone amiss and require interference sooner. Above all things avoid adhesive plates and polluted water. Dry dressings have served me best.

The large majority of the injuries we are called upon to treat are not serious, but for that reason it is no less important to give them the best possible treatment, which include strict antisepsis. It makes a vast difference to the company who pays benefits whether the average loss of time of the injured be three weeks, or six weeks, which ratio would about represent the difference between cases treated antiseptically and those treated otherwise. I have seen one after an antiseptic amputation above the elbow return to work in eight days, while one suffering a similar mutilation accompanied by the former usual course of suppuration, would hardly be expected to return to work in as many weeks.

One antiseptic I wish to mention particularly is a chemical combination of gum camphor and carbolic acid in equal proportions. It is well to make the proportion of camphor slightly in excess to be sure that there is no free carbolic acid present. It is not only a powerful antiseptic but is also a powerful local anesthetic as well, and is practically unirritating and non-poisonous withal. Its

range of application is wide. It may be applied to mucous or raw surfaces or inflamed integuments. One application will cure ring-worm. I think it would be valuable in rhus toxicodendron poisoning, erysipelas and eczema.

In burns, I have found it a most excellent application, its anodyne properties being not the least important. In extensive burns of all degrees, I have applied it full strength with immediate relief to suffering and without the manifestation of toxic symptoms, but perhaps mixed with six or eight parts of olive oil it would be as effective.

It is insoluble in water, glycerine, or linseed oil, but is a solvent of various chemicals, such as camphor, which it dissolves in large proportion; menthol

and chloral, each of which it dissolves in equal parts; iodine, in the proportion of 1 in 30; cocaine, 1 in 10; and morphia, 1 in 30. It is itself soluble in olive oil in the proportion of 1 to 2, and vaseline in the proportion of 1 to 3. In alcohol it dissolves freely.

Now, gentlemen, I would say in conclusion, that, while I have been unable to present anything particularly new on this subject, if I have succeeded in awakening any who are inclined to be lax in antiseptic practices to a realization of their supreme importance, or have been able to point out simple and practical means for their application, the object sought by this paper will have been attained.

**TREATMENT OF DIABETES.** — The treatment of diabetes is often discussed by therapeutists who have new methods to offer with the hope of curing or staying the progress of this wasting disease. Dr. J. Blake White, after relating his experience and surveying the literature of the treatment of this disease in the *American Medico-Surgical Bulletin*, concludes that from internal antiseptics he has had the most beneficial results and especially with a substance called benzosal or benzoyl-guaiacol. He found that with the use of this drug severe cases became mild ones and mild ones were cured.

It is not easy to give its mode of action, but the fact remains that it has done good and it deserves a further trial. It is a colorless, odorless, tasteless crystalline powder, soluble in chloroform, ether and hot alcohol. In the intestinal canal it is transformed into guaiacol and benzoic acid. The dose is one drachm daily in distributed doses. It is just as well to restrict the diet and also to give the carbonate of lithium and Fowler's solution in vichy every morning.

\* \* \*

**RESPONSIBILITY OF INFANT MORTALITY.** — The high mortality among the newly born or those under six weeks

might please the disciples of Malthus but it causes Dr. M. A. Crockett to ask in the *Medical News* if the physician is in any way responsible for the high mortality at this early stage of existence. His conclusions gleaned from statistics gathered in various countries are :

1. The mortality of the newly born is both absolutely and relatively disgracefully high.
2. Septic infection causes a part of this mortality, and is preventable.
3. Asepsis should be observed about the newborn child. Dirty fingers or instruments should not be introduced into the child's mouth in cases of asphyxia. The child should not be allowed to ingest pus with its milk.
4. The navel should be treated on modern surgical principles and have the personal supervision of the physician.
5. The physician should take the child's temperature as well as that of the mother, bearing in mind that many of the septic diseases have an insidious approach, and that the importance of the thermometer cannot be overestimated.
6. The navel-wound may be the path of infection without showing signs of local inflammation.
7. Close observation of the newborn infant will teach the physician much and benefit the child greatly.

**SOCIETY REPORTS.****TRI-STATE  
MEDICAL ASSOCIATION**

OF WESTERN MARYLAND, WESTERN PENN-  
SYLVANIA AND WEST VIRGINIA.

SEMI-ANNUAL MEETING HELD AT [CUMBERLAND, MD.,  
DECEMBER 12, 1895.

The Semi-Annual Meeting of the Tri-State Medical Association of Western Pennsylvania, Western Maryland and West Virginia met in the City Hall on Thursday, December 12, at 1.30 P. M.

The session opened with about forty members; a number coming in later swelled the attendance to about sixty. Dr. C. S. Hoffman of Keyser, West Virginia, the President, called the Association to order and Rev. Charles E. Raymond opened with prayer. Dr. Wm. J. Craigen, in the name of the Cumberland physicians, welcomed the members to the city and Dr. S. H. Gump of Bedford responded for the visitors.

*Dr. J. A. Lippincott* of Pittsburgh, after the regular routine business, opened the medical discussion by an address on Iritis, and preceded his remarks on the disease with an account of the anatomical structure and relations of the iris, illustrating the latter by means of blackboard drawings. After giving the symptomatology he dwelt at some length on the means of distinguishing iritis from other inflammatory affections of the eye, especially conjunctivitis and glaucoma. In discussing the therapeutics of iritis he attached especial importance to the vigorous use of atropine and also to leeches, hot poultices, and hot water. In reference to atropine, he recommended caution in the application of this remedy where there was evidence of cyclitis, such as tenderness in the ciliary region, edema of the upper lids and pain following the application of the drug. As to the treatment of the adhesions resulting from the disease he advised that isolated posterior synechiae which did not yield to atropine should be left alone. He advised iridectomy in cases of total seclusion of the pupil as a therapeutic measure. He also de-

scribed an operation which he had recently performed for total posterior synechia accompanied by opacity of lens. In this case a free iridectomy was first performed upwards. Five weeks later, an incision having been made at the lower corneal margin, a bit of the iris was clipped out, giving a circular aperture in this membrane near its lower periphery. A Wecker's scissors with two blunt points was then introduced into the incision; and, one blade having been inserted through the circular opening beneath the iris at the outer side, the other remaining in front of the iris, the scissors were pushed upwards and closed, thus severing the lens from its iris attachment on that side. A similar cut was made on the other side. The wire scoop was now introduced beneath the lens and the latter was removed without any loss of vitreous. The wound healed promptly and the visual result was such that the patient was able to walk about. The ophthalmoscope showed the media to be perfectly transparent and the imperfection of vision was shown to be due to choroidal atrophy.

This was listened to with marked attention by all present. After his address, on motion of Dr. Good, Dr. Lippincott was given a vote of thanks and elected an honorary member of the Association. Discussion of the subject followed.

*Dr. S. H. Gump*, Bedford, Pa., preferred the iodide of potash and mercury combined, in syphilitic iritis. He used salicylic acid in cider in the rheumatic form.

*Drs. Good and O. M. Hoffman* thought well of the use of leeches in iritis.

*Dr. Lippincott* said he employed blisters, hot poultices and hot water where leeches could not be obtained. He also uses pilocarpine hypodermically, with good results.

*Dr. Robert L. Randolph* of Baltimore: I would call the attention of the general practitioner to one or two other points which are valuable in distinguishing this disease from conjunctivitis. I refer first to the return of the hyperemia. In iritis the hyperemia of the eyeball is

more intense immediately at the corneal borders. The blood-vessels are very numerous, very fine and run straight from the limbus of the cornea for a short distance, the conjunctiva becoming less hyperemic as we go towards the lids. The cornea is usually surrounded by this vascular zone, made up of these fine blood-vessels radiating from its border. In conjunctivitis, on the other hand, the hyperemia increases in intensity as we go towards the lids, the blood-vessels appearing large and tortuous. In the latter case the injection has its seat in the conjunctiva, while in the former case the injection is located in the episcleral tissue and always indicates iritis, keratitis, or some involvement of the deeper structures of the eye. The character of the pain is suggestive, too, of the nature of the affection. The pain of iritis is apt to be paroxysmal, coming on frequently at night, and is referred to the temple and forehead, as well as to the eyeball. The pain of conjunctivitis is not usually periodical or paroxysmal in character and it is generally referred solely to the eyeball. I agree with Dr. Lippincott as to his treatment of iritis. I may add, though, that irrespective of the etiology of a case of iritis, whether, in other words, it be due to syphilis or rheumatism, I always commence the treatment with a calomel purge, usually 3 grains in  $\frac{1}{4}$  grain doses, and follow it up with 20 grain doses of salicylate of soda, the latter being continued till the intense pain has subsided or the patient shows marked constitutional symptoms of the drug. After this I follow out much the same line of treatment as Dr. Lippincott has suggested.

Dr. R. L. Randolph of Baltimore read a paper entitled, AN ANALYSIS OF 160 CONSECUTIVE CATARACT OPERATIONS. He said in part: The determining factor in this operation is cleanliness, a factor just as important here as it is in operations upon the brain and abdomen. With the exception of the knife all my instruments are boiled. They are wrapped up in a fresh napkin, the latter is securely pinned, and then dropped into a vessel and boiled for at least five minutes. Without opening the napkin the

latter is taken out and laid on a plate and not touched till the operation is commenced.

The knife is placed in Squibb's absolute alcohol and allowed to remain there for 20 minutes. I have never observed that the edge of the knife was dulled by this method of sterilization. Just before making the corneal incision the knife also is plunged into boiling water and held there for a few seconds. The cocaine and atropia are sterilized in a test tube by boiling. The dropper of course has been boiled. The cocaine and atropia are freshly sterilized for every operation. The bandage and cotton have been subjected to steam sterilization. No anti-septic solutions such as sublimate solutions are used. They irritate the tissues and render them less able to withstand the inroads of organisms. I make an exception in favor of a physiological salt solution, which of course has been sterilized and which is absolutely un-irritating to the conjunctiva. I use it freely during the operation.

Many of these cases were operated upon under most unfavorable conditions and yet in the 160 cases I obtained useful vision in 153. In two of the 7 cases of failure, I think the latter may be attributed in large measure to conditions over which I had no control.

The last twenty-two operations were performed without iridectomy and instead of eserine, atropia was used before and after the operation and with excellent results. I am not prepared though as yet to give any special preference to either of the two operations.

A sumptuous banquet at the Manhattan Café followed. At 8 p. m., the meeting re-convened, with even a larger attendance than in the afternoon. Three new members were elected: Drs. Broadup of Cumberland, Miller of Romney, W. Va., and Clymer of Midlothian, Md.

Dr. O. M. Hoffman reported a PECULIAR CASE OF ERYSIPelas in which there was no elevation of temperature.

Dr. J. J. Wilson reported a case of a boy who died from the effect of poison of snake introduced through scratch on leg.

Resolutions of respect to the memory

of the late Dr. J. Edwin Michael, an honorary member of the Association, were adopted.

*Dr. C. C. Jacobs* of Frostburg, Md., read a paper on APPENDICITIS. (See page 183.)

*Dr. George H. Rohé* of Baltimore read a paper on THE MENTAL DISTURBANCE OF THE CLIMACTERIC PERIOD. Dr. Rohé was elected an honorary member of the Association. His paper was discussed by Drs. A. Enfield, J. J. Wilson, O. M. Hoffman and others.

*Dr. Barton Cooke Hirst's* paper on HYSTERECTOMY FOR PUERPERAL SEPSIS was read by title.

*Dr. J. M. Spear* read a paper on ANTISEPSIS. (See page 186.)

The papers and talks were all excellent, but owing to the large number of them discussion was limited.

The Association adjourned to meet next June.

E. T. DUKE, M. D.,  
Reporter.

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**SEPSIS DURING PREGNANCY.**—Bar and Renon (*British Medical Journal*) read at the recent congress at Bordeaux a clinical report of a case of "streptococcism" in pregnancy. A woman was admitted into hospital suffering from high fever. She was about eight months pregnant, and occasional pains set in. Some cervical secretion was removed for examination before any obstetrical manipulations. Cultivations proved that the secretion contained streptococcus. As the patient was very ill, labor was hastened. Specimens of placental maternal blood were cultivated, and colonies of pure streptococci were obtained. The child died before birth; samples of its blood from the placenta, liver and heart and fragments of the liver and lungs were cultivated. The cultures remained sterile. The mother died fifty-three hours after delivery, and pus was found in the parametrium. Bar and Renon maintain that the "streptococcism" provoked labor. Though the fetus succumbed, there is no evidence that the germs invaded the fetal organism through the placenta.

## CORRESPONDENCE.

### A CORRECTION.

BALTIMORE, December 17, 1895.

Editor MARYLAND MEDICAL JOURNAL.

*Dear Sir:*—I find I made a slight error in my paper published in the MARYLAND MEDICAL JOURNAL of December 7, 1895, on the Treatment of Iritis; I shall therefore ask you to insert the following correction: "In the case of Mrs. P., in whom the iritis preceded the other secondary symptoms of syphilis, I found by careful reference to the dates that the iritis began six weeks before the other signs, and not four weeks before, as is stated."

These cases being very rare, I beg you to make the correction.

Truly yours,  
H. FRIEDENWALD, M. D.

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## MEDICAL PROGRESS.

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**AUTOPSIES AFTER DIPHTHERIA ANTITOXINE TREATMENT.**—Diphtheria is sometimes a pure infection but very often a mixed infection, and the treatment by antitoxine is modified by this fact. Dr. William Royal Stokes gives the results in the *Boston Medical and Surgical Journal* of nine autopsies in cases of diphtheria treated with antitoxine.

In eight of the nine cases of uncomplicated diphtheria to which antitoxine had been given, the bacteriological examination at the autopsy showed a more or less well-marked invasion of the blood by the pyogenic cocci. The results in detail are as follows: In five cases the streptococcus was found in the liver, spleen, kidney and the blood of the heart; in one case in the kidney and blood of the heart; and in one case in the spleen. The pneumococcus (*micrococcus lanceolatus*) was found only infrequently, it being observed in two cases in the kidney, in one of which the streptococcus was also found in the spleen. In the cultures from one case

the only organism present was the bacillus coli communis.

In the lungs of all these cases were found the bacillus diphtheriae, streptococci, pneumococci, and the staphylococcus pyogenes aureus, either alone or in various combinations.

Assuming, therefore, beyond peradventure, the efficacy of this remedy, the importance of its early and thorough administration cannot be overestimated, for by this means the dangers of secondary infection may not only be lessened, but if this condition be present, the system may possibly be better prepared to overcome the ill effects of the various complicating bacteria present in the body.

As to the occurrence of the bacillus diphtheriae in the internal organs in these nine cases, it cannot be said that it has been met with any less frequently than in other cases which have come to autopsy at the City Hospital, and which are referred to above. In these antitoxine cases it has been found in the kidney in four cases, and once in the heart and spleen respectively.

\* \* \*

**FATAL JAUNDICE IN PREGNANCY.**—Demelin (*British Medical Journal*) publishes three cases of marked jaundice during pregnancy, two ending fatally. In the first case jaundice appeared at the fifth month, the temperature was subnormal, no external hemorrhages were seen, and there was no albuminuria. At the end of ten days nervous symptoms set in. Abortion was induced, but the patient died. In the second case icterus continued for several months, and repeated multiple hemorrhages occurred. No albumen was found in the urine. Nerve symptoms set in, and death followed spontaneous delivery at the eighth month. The case which recovered was remarkable on account of the presence of albumen and also blood in the urine, a symptom not observed in the fatal cases. There was at first nervous disturbance, indicating the onset of eclampsia, as well as hemorrhages. The jaundice lasted but a short time, and both mother and child recovered.

No fits actually occurred, and all nerve symptoms were absent when the jaundice began to clear up.

\* \* \*

**CHOLELITHIASIS.**—The diagnosis and treatment of gall stones is the subject of a paper in the *Virginia Medical Monthly* by Dr. George Ben Johnston of Richmond. Gall stones occur in persons over thirty and in women four times as often as in men, especially in women who have borne children. Obesity, tight lacing and sedentary habits may cause them and obstruction to the flow of bile in the duct is the chief causative factor.

Probably ten per cent. of the cases have no symptoms and can never be discovered. Colicky pains in the region of the duct are the first symptoms. Small stones may be found by sifting the feces through a sieve. Besides pain there is shivering and vomiting. When the stone becomes impacted jaundice follows.

Biliary colic may be mistaken for renal colic, cancer, tabes dorsalis, lead colic, appendicitis, etc., but cases were differentiated. There is no medical treatment but morphia. Surgical interference is proper and usually gives relief.

\* \* \*

**THE UTERUS IN ECTOPIC GESTATION.**—Pilliet, in the *British Medical Journal*, has studied the histology of the modifications which the uterus undergoes in tubal gestation. He finds that the development of a decidua in its empty cavity during ectopic pregnancy is more than a pathological phenomenon; it is a distinct clinical complication. As long as the decidua remains in place the uterus is practically in a condition of subinvolution; hence both hemorrhages and membranous dysmenorrhea may occur. When the decidua has been shed there is danger of diffusion of metritis to the whole uterine muscle. Pilliet adds rather significantly that the etiology and pathology of endometritis are both obscure, and that probably ectopic gestation, overlooked in its early stages, may account for many peculiarities in cases of endometritis hitherto hard to explain.

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BALTIMORE, DECEMBER 28, 1895.

**ANNOUNCEMENT.**

WITH the desire to improve the literary character of the MARYLAND MEDICAL JOURNAL, the management has arranged with a number of specialists of prominence to act as collaborators throughout the year 1896. Each collaborator will have charge of one department and will give a careful critical review of books, a report on the progress of medicine and contribute editorials in his special department. It is hoped in this way to materially strengthen the standing of the JOURNAL, and to give the readers as good matter as is possible from the material within the State of Maryland and the District of Columbia.

A Journal is not always what the editors make it, but depends on the literary center in which it lives. The endeavor will be to give work principally of a practical nature, but the results of scientific and laboratory work will not be passed over. If it is found that the proposed division of labor and infusion of new literary blood meets with the approval and support of the readers, the JOURNAL will then be ready to make other advances.

ONE of the great dangers of major operations is the administration of the anesthetic even when the anesthetist is skilled, and many a piece of surgery well done ends fatally through the evil effects of the sleep-producer. In minor surgery timid persons cannot stand even the momentary pain and some, too often of the so-called stronger sex, demand a total unconsciousness rather than submit to the momentary pain of an abscess opening or slight operation on the eye.

The use of cocaine has in a measure been of great assistance in these small operations, but of late Schleich of Berlin, in his article on "Schmerzlose Operationen," has devised a means of making the skin anesthetic for a short time in minor operations. Würdemann, in reviewing this work in the *Journal of the American Medical Association*, gives his experience with this new method in diseases of the eye, and Van Hook, in the *Medical News*, reports the result of his work in general surgery.

Schleich after some experimentation found that very small quantities of cocaine and morphia dissolved in a 0.2 per cent. salt solution and injected into and not under the skin, produced a localized anesthesia which lasted from ten to twenty minutes and often longer, allowing of cutting with no pain at all.

The skin is first made aseptic, then pinched up and the sterilized needle of the syringe containing the solution, which should be cold, is passed obliquely under the epidermis and a few drops injected until a white elevated wheal appears. The needle is withdrawn and inserted at the edge of this wheal and so on until an area as large as may be desired is made anesthetic. If the spot to be cut is first cooled by an ether or rhigolene spray, if it is the skin, and by a strong solution of carbolic acid, if it is the mucous membrane, the prick of the needle is not even felt, but in the case of the small needle which should be used, the pain is almost nil, especially when the skin is pinched. Würdemann has used this method in operations about the eye and also in abscesses and felonies with success. Schleich has even done celiotomies with it, but others might not dare to follow this lead.

The solution most usually employed is a grain and a half of cocaine, one-third of a

grain of morphia and three grains of sodium chloride in three ounces and three drachms of sterilized water. Two other solutions, one containing double the quantity of cocaine and the other one-tenth the amount, are also used.

The value of this operation is in the technique, and stress is laid on the point that the needle must not go beneath the skin. This process is capable of development and is worthy of a careful trial.

\* \* \*

THE nervous system of the infant and growing child is so delicately balanced that any irritation if continued is likely

*Circumcision.* to produce vague, or even pronounced, trouble, often at such a great distance from the seat of irritation, that the real cause of the trouble is little suspected except by the most expert. It is partly on this account that Dr. Stone in a late issue advocates circumcision in the case of all infants.

While the feasibility of a wholesale preputial amputation may be questioned, still there are so many cases where the shortening of the covering of the glans penis would be of benefit, that the family physician should examine every infant under his care with the idea of circumcision. That it does cause irritation from the tight constriction of the fore-skin, from the collection of smegma and other excretions behind the head of the glans penis, is a fact of every-day observation. The Jews, who as a part of the old Hebrew ritual, perform this operation on all male children very soon after birth, have been shown to be freer from disorders caused by a long prepuce than other races.

The operation, as Dr. Stone shows, is easy and simple, producing little pain; but care and antiseptic precautions should be used, and if the rites of the Jews demand that the circumciser should perform the operation, he should do it in the most approved manner and not infect the wound of the cut foreskin. Even if vague symptoms referred to a phimosis or paraphimosis do not disappear on completion of the operation, improvement may come later, and even if no improvement results at all the operation will have done no harm.

In the present craze for major operations, such little trivial work is apt to be neglected.

The infant and young child cannot give a clear picture of its trouble and the pediatrician, like the veterinarian, must rely on objective signs and use his powers of observation and his good sense.

\* \* \*

NEW forms of iron, that strong tonic and reconstructive, are introduced from time to time by scientific phar-

*Iron and the Teeth.* macists and chemists, but some physicians still stick by their old friend the tincture of the chloride of iron in spite of objections to it. Not only is it very unpleasant to take, but the effects on the teeth are very serious and lasting.

In the *Dominion Dental Journal*, Dr. G. D. Martin, a dentist of Toronto, takes up the effects of this form of iron on the teeth and thinks that it is a very delicate question as affecting the relations existing between physicians and dentists. He says it is clearly laid down in works on *materia medica* and *therapeutics*, that this form of iron is especially injurious to the teeth and should be used with great caution, and yet he is led to believe from his own and others' experience that physicians are lamentably careless and not conscientious in not warning patients against its dangers.

Druggists have informed him that most of the prescriptions containing this form or any form of iron include no word of caution about the injury that may be caused to the teeth. He says that it has been shown by experiments on teeth that the tincture of the ferric chloride diluted is even more dangerous and injurious to the teeth than when undiluted. That manufacturing pharmacists are aware of this danger is evidenced by the large number of elegant preparations of iron made with the object of avoiding this dangerous element of corroding the teeth. Even the use of alkaline gargles, both before and after taking the iron, may be the best way of counteracting the effects of the iron, but it does not prevent it effectually. Dentists cannot say what remedies physicians shall use, but they can point out to physicians the harm done to the teeth.

The point of the writer is well taken and physicians are not sufficiently careful in prescribing iron, for even if taken through a tube some of the acid will in time affect the teeth if the iron be taken for a long time.

## MEDICAL ITEMS.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending December 21, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		28
Phthisis Pulmonalis.....		35
Measles.....	119	4
Whooping Cough.....	6	
Pseudo-membranous Croup and Diphtheria.	14	8
Mumps.....		
Scarlet fever.....	15	5
Varioloid.....		
Varicella.....		
Typhoid fever.....	9	6

The Queen of Portugal is studying medicine.

Philadelphia has a colored hospital and training school for nurses.

"Knock-out drops" are said to contain a fifty per cent. solution of chloral hydrate.

The Presbyterian Hospital of New York last year spent almost one hundred thousand dollars above its receipts.

Professor Loeffler, the discoverer of the diphtheria bacillus, has been decorated by the French Government with the Cross of the Legion of Honor.

*The College and Clinical Record* of Philadelphia will be hereafter known under the name of *Dunglison's College and Clinical Record*: A Monthly Journal of Practical Medicine.

The Board of Health of the State of New York has decided to submit and recommend to the Legislature a bill forbidding the sale of milk containing tubercle bacilli. The bill will require those who sell milk to show that their cows are free from the disease in question. A proof will consist of a certificate, issued by the Board or its authorized agents, after an examination made by competent persons.

The Baily & Fairchild Company of New York announce the establishment of the Doc-

tor's Story Series, to be issued quarterly. Each number will consist of a complete work of fiction by medical authors. Only such works as are of established value will be reproduced in this popular form. King's "Stories of a Country Doctor" will be issued in January, 1896, to be followed in March by Dr. Phillips' novel "Miskel" and later by a novel now in preparation by the same author.

Dr. George H. Rohé, Secretary and Treasurer of the Rush Monument Committee, reports that up to December 21, 1895, the following amounts have been received:

October 5, Dr. J. W. Russell	\$ 1.00
November 6, Newark, N. J., Practitioner's Club (through Dr. J. D. Brumley)	12.00
December 5, Dr. J. B. Hamilton, Chicago	43.00
December 10, Dr. J. L. Thompson, Indianapolis	5.00
December 14, Dr. J. H. Kellogg, Battle Creek, Mich.	5.00
December 19, Rush Medical College, Chicago	100.00
December 20, Interest	25.00
Previously reported	3357.39
Total,	3548.39

At a meeting of the Faculty of Physic of the University of Maryland, held on December 8, 1895, the following Memorial Minute was adopted: "The Faculty of Physic of the University of Maryland are profoundly conscious of the great loss which has been sustained by this School of Medicine, by the Medical Profession and by themselves in the death of Professor J. Edwin Michael, M. D. From his excellent abilities and from the extent and variety of his professional attainments, Professor Michael was a most useful and successful teacher in several departments of medical science, inspiring always in his pupils the earnestness and enthusiasm with which he devoted himself to his professional duties. As a practitioner he was characterized by skill and judgment which caused him to be regarded as a most valuable counsellor by the many members of his profession who sought his aid. In his manliness and generosity and in his constant readiness to devote himself to the service of others was found his best title to the loving and lasting remembrance of his colleagues and friends."

## WASHINGTON NOTES.

The regular meeting of the Clinico-Pathological Society was held on Tuesday evening, December 17, the President, Dr. H. B. Deale, in the chair. Dr. Wm. M. Sprigg read the paper of the evening, entitled "Pneumonia." After much discussion by the members, the meeting adjourned.

The Medical Society of the District of Columbia held its regular meeting Wednesday evening, December 18. Dr. Samuel C. Busey delivered the President's Address for 1895. "Compulsory Reports of Zymotic Diseases; Milk Legislation; Medical Practice Laws; and Society Publication of its Transactions."

The Washington Obstetrical and Gynecological Society held its regular meeting on Friday evening, December 20, the President, Dr. George Byrd Harrison, in the chair. Dr. S. S. Adams reported a "Case of Typhoid Fever in a Child Under Two Years of Age." It was discussed by Drs. G. Wythe Cook and Rupert Norton. Dr. H. B. Deale reported a case of "Puerperal Convulsions," which was discussed by Drs. J. T. Kelly, G. N. Acker, J. W. Bovée and others. Dr. J. F. Scott reported a case of "Sulphide of Hydrogen in the Urine."

The successful candidates in the competitive nominations at the Emergency Hospital, on Friday, December 20, were Dr. B. F. McGrath of Georgetown University, D. C., Dr. Mox Peralto of Jefferson Medical College of Philadelphia and Dr. W. E. West of the College of Physicians and Surgeons of New York City.

Dr. T. B. McDonald has been appointed Resident Physician of the Washington Asylum Hospital, in place of Dr. V. B. Jackson, resigned.

The pupils of Norwood Institute, after hearing a stirring letter from Dr. S. S. Adams, determined to apply their fund of \$981.10 toward establishing a pathological laboratory in the Children's Hospital.

## REPRINTS, ETC., RECEIVED.

The Treatment of Diphtheria with Diphtheria Antitoxine. By Edwin Rosenthal, M. D., Philadelphia.

Chronic Progressive Chorea. By William Francis Dewry, M. D., of Petersburg, Virginia. Reprint from the *Charlotte Medical Journal*.

## BOOK REVIEWS.

**HISTORY OF ANESTHESIA ; OR PAINLESS SURGERY.** By William R. Hayden, M. D. New York : International Journal of Surgery. Price 25 cents.

For the second time the writer has enjoyed the pleasure and profit of reading this little volume, "written with an honest and unselfish desire to do justice to one whose inestimable services to humanity were persistently overshadowed by the most extraordinary perversion of facts." Should there be any doubt in the mind of the reader as he begins the perusal of this book his convictions as to the real facts in the case would be quite clear before finishing. Dr. Hayden has at great labor and expense as well as honest ingenuity presented to the world all that is worthy of consideration in establishing the points at issue, and we do not see how any candid mind can undertake to controvert the statements published. The simplicity of style and the logical deductions which characterize the contents, together with the recognition the author enjoys in the ranks of the profession through his valuable contributions to medical science, re-enforce his arguments from beginning to end. Dr. Hayden is a member of the Massachusetts Legislature for 1896, and the matter of honoring Dr. Morton will in all probability be brought before both houses for proper action. Physicians in all parts of the country will be glad to see justice done the great discoverer and demonstrator.

**THE PHYSICIAN'S VISITING LIST** (Lindsay & Blakiston) for 1896. Forty-fifth Year of its Publication. Philadelphia : P. Blakiston, Son & Co.

**THE MEDICAL NEWS VISITING LIST.** 1896. Philadelphia : Lea Brothers & Co.

**THE MEDICAL RECORD VISITING LIST, or Physician's Diary** for 1896. New York : William Wood & Co.

These lists have the changes in them that one would expect in a year. The Medical News List is better bound than the other two. The Physician's List has the fault so often noticed before—a weak pocket. Its drug list is not quite up to those in the other two. The Medical News List contains almost too much reading matter, but the thumb index is a great convenience. No one will go far wrong in buying one. The Physician's Visiting List is less bulky.

## CURRENT EDITORIAL COMMENT.

## PUBLISHERS' DEPARTMENT.

## CLUB AND SOCIETY PRACTICE.

*Cincinnati Lancet-Clinic.*

IN some European States club and society practice have reduced professional compensation to so small an amount that it has no doubt been a prominent factor in keeping out of the medical profession many who would have been through this channel an honor to themselves and a blessing to humanity. The evil seed has been carried across the Atlantic and some of it has fallen in fruitful soil in almost, if not in every, American city.

## TEMPERANCE TEACHING.

*Boston Medical and Surgical Journal.*

THERE is one point which would bear a little more emphasis: that only "in a narrow and limited sense does the word temperance stand for abjuring that which intoxicates, that in its broader and truer sense the word stands for high self-control and self-respect." It would be a pity that the youthful mind should not be made to understand that even an advocate of "temperance," in the narrow sense, who abjures alcoholic stimulants may still be a very intemperate person. Let the young learn that temperance means moderation, and above all self-control.

## PNEUMONIA.

*Lancet.*

AS REGARDS pneumonia we have no specific remedy, but it may be fairly enough argued that the bacillary theory of the disease, however problematical it may still remain, suggests the wisdom of caution in pushing either an antiphlogistic or a stimulant line of medication. The reasonable and moderate treatment of symptoms must commend itself to every judicious practitioner; but wholesale bleeding on the one hand, or drenching pneumonic patients with alcohol on the other, seems, in the light of recent researches, more indefensible than ever. Similarly the routine use of antipyretics seems bad practice. All the evidence at our command appears to show that, apart from hyperpyrexia, the height of the temperature bears no direct relation to the danger of the attack in pneumonia.

All letters containing business communications, or referring to the publication, subscription, or advertising department of this Journal, should be addressed as undersigned.

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**WANTED.**—A young physician as assistant in a general hospital. Address St. Joseph's Hospital, Caroline and Hoffman Streets, Baltimore.

## NOTES.

MALAKIN has been used with success in a number of cases in the pyrexia of rheumatism.

\*

OUT of six cases of parotitis purulenta Janowski found that five were caused by staphylococci and streptococci, and one by the typhoid bacillus.

\*

A NEW galactagogue is promised in a plant known as the common goat's rue, *galega officinalis*. One drachm of the tincture is given about five times a day.

\*

A FECAL cecitis should be diagnosed from appendicitis by a history of prolonged constipation, late appearing fever, pain of long duration and a doughy tumor of considerable size in the lumbar region.

\*

IN incoercible vomiting of pregnancy apply the continuous current, placing the positive pole on the clavicle, between the two branches of the sterno-cleido-mastoid, and the negative pole over the umbilicus.

\*

NITRO-GLYCERINE is a valuable remedy in the treatment of sciatica. The dose is one drop of a one per cent. alcoholic solution three times a day, although larger doses may be required.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### THE CIRRHOTIC KIDNEY.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
NOVEMBER 19, 1895.

By R. M. Baker, M. D.,  
Washington, D. C.

IN what I have to say of cirrhosis of the kidney tonight, I have thought it well to confine myself mainly to the clinical symptoms of the disease and their explanation founded on its pathology and to present as nearly as possible its clinico-pathological aspect.

When we remember that there are many cases where the existence of cirrhotic kidney has not been discovered nor even suspected until post-mortem, its victim having succumbed to acute uremia, cerebral apoplexy, or some intercurrent disease, we are more ready to believe that the glandular structure of the kidney may be in a great part destroyed by the cirrhotic change without definite symptoms developing. At times we see those in whom the kidneys are much diseased in apparently perfect health, attending to their usual duties or pleasures, and generally considered to be healthy members of the community. In other cases symptoms develop comparatively early, such as headache, which is often severe and protracted, and digestive or urinary disturbances.

We have all found that examinations of the urine in cases of protracted headache have thrown light on otherwise obscure cases. Bartels, indeed, suggests the feasibility of considering the diagnosis of cirrhotic kidney in cases of

severe migraine occurring in those beyond middle life, who are otherwise in good health. At times there are attacks of palpitation, occasionally accompanied by vertigo, but more often in a feeling of weariness, even of suffocation. A careful examination of the heart may here disclose some enlargement of the left ventricle, but it is rare that the disease is diagnosed until the hypertrophy is well advanced. In many cases the excessive secretion of urine is the first symptom noticed by the patient and the one which bade him to consult a physician. An examination of the urine will show it to be of a pale, sometimes greenish color, with specific gravity ranging from 1010 to 1015, occasionally as low as 1005. It may or may not contain albumen, but a careful microscopic examination will generally show a few hyaline casts. Upon questioning the patient, we are apt to find that he is obliged to get up at night to pass urine, but that he can go for several hours during the day without inconvenience.

This nocturnal disturbance seems to be a peculiarity in many cases, though in others the urine is not passed more freely than during the day. Upon further examination, if the polyuria be due to cirrhotic kidney we will find a distinct hypertrophy of the left ventricle

and a tense radial pulse, the hypertrophy being recognized by heaving impulse, apex beat displaced to left and accentuated second aortic sound. This hypertrophy was observed by Bright, but attributed by him to the impure blood acting directly on the heart muscle. Were this the sole cause we would expect hypertrophy of the right ventricle also. Gull and Sutton viewed the changes occurring in the arteries and heart as a part of a general arterial fibrosis; it was a disease of senility, according to them, but of the 33 cases which Bartels followed to the post-mortem table 17 were under 40 years of age. Gull and Sutton said that the cardiac hypertrophy failed to appear in some instances of cirrhotic kidney and was absent generally in cases where the kidneys were nearly destroyed by other disease, *e. g.*, the tuberculous kidney.

Johnson endeavored to explain the absence of cardiac hypertrophy in particular cases of renal contraction, as due to conditions of general defective nutrition. He thought the whole state of the change was rooted in the kidneys, which failed to purify the blood. This impure blood, he argued, was offensive to the body, therefore the muscular arterioles contracted to keep it from the capillaries and tissues and the heart hypertrophied in attempting to drive the blood through the unsound channel. Traube was the first to say that cirrhosis of the kidney was a distinct disease, distinguishable from the other forms of Bright's disease. He held that the seat of the disease was in the interstitial tissue and the destruction of the renal capillaries in the defective elimination of water led to increased tension in the aortic, therefore dilatation and hypertrophy of the left ventricle to compensate. It has been shown that defective elimination of water could not raise the arterial pressure nor is there defective elimination of water in cirrhotic kidney. But that the destruction of the renal capillaries is a decided element in the increased blood pressure and so a cause of hypertrophy of the heart has been generally accepted.

Grawitz and Israel found that after temporarily clamping the renal artery,

they got a diffuse nephritis which passed indifferently into either the cirrhotic kidney or the large white kidney; and it has been found that complete ligation of both renal arteries does not raise the arterial pressure, because other vascular regions dilate to receive the blood. Here, however, we have a sudden change, instead of a gradual one. If we examine under the microscope a section taken from the cirrhotic kidney, we find a decided increase in the connective tissue of Bowman's capsule (which invests the glomeruli) and of the outer walls of the blood-vessels. The capillaries of the glomeruli are partly destroyed with their epithelium and in places the whole glomeruli destroyed. Some of the tubules are collapsed, some have their epithelium, some have not.

Be the explanation of the hypertrophy what it may, it is a constant symptom, unless the cirrhosis occur in weak or anemic subjects. Sometimes this hypertrophied heart and increased arterial tension find expression in hemorrhages into internal organs, death not infrequently resulting from a hemorrhage into the brain. Or there may be hemorrhages into the dura mater, occasionally giving rise to convulsions without paralysis. These convulsions, however, are generally unilateral and to be distinguished from true uremic convulsions in which the whole body is involved, and which at times come on without the slightest warning. So severe and intractable are these uremic convulsions that they sometimes terminate in death. A feature that it is well to notice is their distinctly epileptic character, the face becoming cyanotic, the pulse small and hardly to be felt, bloody froth at the mouth and respiration at times almost ceasing. The attacks are generally repeated at short intervals, so that there may be ten, twenty, or even more, in a day, the patient being comatose in the intervals. They are probably due to defective elimination of urea, or other excretory product, though an edema of the brain has been suggested. These successive attacks may or may not occur in patients who have edema of the ankles or face. Here the condition of the heart

may furnish valuable aid in the prognosis, the existence of hypertrophy indicating that we have to deal with a condition which has been gradually increasing for years. In two cases mentioned by our writer death was due to uncontrollable nose-bleed.

When the heart begins to fail, the blood pressure falls, the kidneys get rid of their water and we find accumulations of fluid in various parts of the body. It rarely happens that this edema is extensive until late in the disease. Stains of blood will appear in the lungs, causing shortness of breath, cough which is often obstinate, or at times even attacks of acute edema of the lungs, with expectorations of a bloody, frothy mucus, or attacks referable to the heart and closely resembling angina pectoris, may occur. I think I have seen one such case recently where there was much pain and discomfort over the heart. The superficial arteries were tense, and an examination of the urine has shown a small amount of albumen with a deficient elimination of urea. Again, digestive symptoms may occur, as failing

appetite, vomiting and irregular action of the bowels. As symptoms which usher in the last stage are obstinate vomiting, a characteristic of which is that it occurs when the stomach is empty, as upon waking in the morning, and consists of a faintly acid, sometimes alkaline, watery fluid containing shreds of mucus. If diarrhea occurs, it usually ushers in the last stage. The stools are excessively fetid, and the strength fails rapidly, the patient gradually becoming more and more comatose. A very troublesome and obstinate symptom of some cases is intense itching of the skin, lasting for days and very intractable to treatment. The breath and perspiration in these chronic anemic cases have a most offensive uremic odor.

As causes of this disease are mentioned lead poisoning, gout and alcohol. Thus Bartels states that during twenty-five years' active service as a hospital physician, in only three cases had he found cirrhotic kidneys in bodies of habitual drunkards and that most of those affected with this disease had led remarkably abstemious lives.

## TUMOR OF THE EYEBALL.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
NOVEMBER 19, 1895.

*By Louis Mackall, M. D.,*  
Washington, D. C.

ALICE MITCHELL, aged 30, came into the Lutheran Dispensary about November 1, and through the kindness of Dr. Butler I bring her here tonight for your inspection, as her condition is not only a rare one but is also very interesting from an ophthalmological standpoint.

She says that her trouble commenced about the latter part of August with sharp pains through and over the eye. The pain in the temporal region continued up to admission into the dispensary. She went to a Dr. Woodruff about October 15, who gave her an eye-drop for the pain from which she was suffering. She thinks that this eye-drop produced all her trouble. She says that her eye commenced to swell imme-

diate after the drop was instilled into the eye.

At the time of her admission the eye was immovable, the pupil dilated and immovable. There was marked exophthalmos and marked chemosis extending out of the lids. The iris of her left eye was bound down and there was a good deal of lymph in the pupil. She gives a history of traumatism in this eye in 1876. With this eye she had a vision of  $\frac{6}{24}$ . Upon admission she could not count fingers with the right eye but at the present time she can.

The fundus of the eye upon ophthalmoscopic examination was found to be normal and the media were clear except the lower section of the lens, which was cataractous. Her temperature was

taken on November 13 and found to be 100° F. The tension was somewhat plus on admission. She has not given any history of chills. Dr. Butler has passed a bistoury beneath the globe to the posterior wall of the orbit upon several occasions but has never drawn any pus. He has scarified the chemosis several times without drawing much blood.

On November 13 the outer canthus of the eye was slit up because it was thought that perhaps the lid, which was very tight beneath the projecting tissue, was keeping up the chemosis. This caused a considerable bleeding. She said Saturday that there had been some

discharge of bloody matter during the night previous but did not think there was a teaspoonful.

She is taking iodide of potash and has been keeping warm applications to the eye. Her condition has not changed much since her admission. The exophthalmos is not so marked but the chemosis has steadily increased. The pain entirely ceased after the first incision and she has had none since.

At first we thought that this was a retro-bulbar abscess, but the impression has been growing that it must be a malignant growth and Dr. Butler intends to take a piece out for microscopical examinations.

## SUGGESTION IN THE OPERATION OF CIRCUMCISION.

*By T. Richie Stone, M. D.,  
Washington, D. C.*

In the light of the modern advancement of surgery with all its antiseptic precautions so necessary for success, many are apt to view with contempt this simple though essential operation, so pardon may be granted in using the old adage of "anything worth doing, is worth doing well."

The operation is one which I have performed many times and is essentially the same presented before the Clinico-Pathological Society of this city some years ago, but now revised with the modifications which experience has given.

In its performance a little more time may be expended, but wisdom gained by practice has demonstrated that the result amply compensates for the trouble. In making the markings for cutting, any amount of the redundant prepuce may be included, but of course enough tissue must be removed to overcome the stenosis present.

*Operation.*—The penis after being made practically aseptic and dried with sterilized cloths is marked, in the flaccid state, externally from a point on the dorsum from about the middle of the coronal ridge round and downward to the frenum. The frenum is located through the medium of feeling the band-

like insertion, or when the prepuce is pulled forward a needle can be stuck through from the internal to the external side (at the internal insertion) and thus form a guide, or, after the first dorsal incision is made, any correction in the external making can be perfected. This is the line of incision.

Your assistant having applied to each side of the prepuce (dorsum) locked-forceps, now pulls the prepuce as far forward as possible, at the same time dilating the orifice. The first cut is made while on the stretch in a line down the middle of the dorsum of the prepuce to the point marked on the corona, the two flaps are pulled aside and any existing adhesions broken down.

The two flaps made by the middle incision of the prepuce are firmly held apart by locked-forceps such as hemostatic. This is the most important step in the operation, and if not strictly observed, the object is lost. The reason for the locked-forceps on the flaps is, that the under or mucous layer may be stretched upon the upper or dermoid layer, so that there will be no rolling or movement of the two layers, but will be firmly fixed on each other.

The next step is to put in the sutures while the flaps are on the stretch, begin-

ning at the median line and following the external marking, and carried downwards and around to the frenum. They should be placed close together.

Here I must say that too few sutures are many times the cause of the malformations which should be carefully guarded against. The sutures (which are cut long) being in place, and caught at each end so as to cause no tangled obstruction, the half flap of redundant prepuce is cut around, following the marked external line. The other side is treated in the same manner, bleeding vessels ligated, sutures tied, dry dressings put on, and your operation is finished.

In doing this operation, as much of the prepuce may be removed as desired, and I quote from a paper by Dr. H. G. Howse in a "Note on the Operation of Circumcision in the Adult," in Guy's Hospital Reports, London, 1873, third series, Vol. 18: "The frenum may be looked upon as a mere fetal remnant, having no very definite function. On the other hand, its presence is sometimes decidedly prejudicial." Economy in sparing the tissues or cutting the frenum does not play such an important part, for usually the amount left in many of the operations for phimosis leaves

the patient with a ridge or stump of amputated prepuce which neither enhances the beauty nor usefulness of the organ; hence would suggest leaving the glans uncovered.

Again, many operators usually include bleeding points in their sutures, but if all bleeding points are carefully attended to before the sutures are finally closed, the operator would not be troubled by the midnight bell with its hurried summons.

All that is claimed is:

First. Quickness—the one cut (of the divided prepuce) being all that is required; obviating the necessity of trimming the under or mucous layer after the clamp is removed.

Second. The approximation or coaptation of the two edges are better acquired and there being no necessity for lost time in putting in sutures in the two surfaces far apart.

Third. The needles are put through with more ease, as both surfaces are together on the stretch.

Fourth. There being no cause to fear secondary hemorrhage as all bleeding vessels are tied and the sutures being evenly and correctly put in, the bleeding, which is parenchymatous, is controlled.

**RECURRING ASCITES, WITH REMARKABLE COMPLICATIONS.**—The *Archives of Pediatrics* for January contains a paper on recurring ascites associated with enormous heart hypertrophy and chronic proliferative peritonitis, by Dr. William Osler. It is based on the case of a girl eleven years of age, who within a period of three years was tapped 121 times for ascites.

The points of particular interest in the case were: The enormous hypertrophy and dilatation of the heart with only partial pericardial adhesions; the clinical picture of mitral valve disease, which most of these cases of adherent pericardium present so soon as the cardiac dilatation becomes excessive; the diastolic murmur along the left sternal margin which was probably associated

with insufficiency of the valves of the pulmonary artery—Graham Steell's murmur of increased pulmonary tension; the subcutaneous fibroid nodules in a child who had never had acute arthritis and who had no mitral valve disease; and lastly, the remarkable tumor formed by the pulsating liver.

\* \*

**A NEW NASAL TABLET.**—Dr. Murray McFarlane of Toronto having become dissatisfied with the Seiler's and Dobell's solutions as being too irritating in the majority of cases, has used with success a tablet containing the soluble salts of the blood plasma, which when added to two ounces of lukewarm water, forms a solution like blood plasma. Each tablet contains  $\frac{1}{16}$  of a grain of menthol.

## Society Reports.

### THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.

MEETING HELD NOVEMBER 19, 1895.

*Dr. Snyder* exhibited the specimen from a case of APPENDICITIS, with the appendix vermiciformis taken from the patient, at the autopsy. The history of the case was that the patient, a boy, had eaten largely of walnuts before retiring, and was taken ill in the morning with violent cramps, vomiting and later symptoms of peritonitis. When he was seen by Dr. Snyder he was almost *in extremis* and an operation could not be attempted. The autopsy showed the abdomen filled with pus, and general peritonitis to have existed. A concretion about the size of a pea, presumably fecal matter, was found in the appendix. The boy was taken ill on Friday, and died the following Wednesday.

*Dr. Olin Leech* thought this was another case showing the importance of an early operation in appendicitis.

*Dr. Mackall* saw the case and thought that Dr. Snyder was called much too late.

*Dr. Bowen* remarked that some years ago nearly everyone operating for appendicitis seemed to find some foreign body, such as seeds, in the appendix, but now this is rare, and only concreted fecal matter is found.

*Dr. Van Rensselaer* spoke of a discussion at the Gynecological Society in which this subject was brought up and different members cited cases in which foreign bodies were undoubtedly found. Of course the concreted fecal matter could resemble seeds of various kinds so closely that a mistake could easily be made but there was no doubt that foreign bodies are found in the appendix.

*Dr. Bowen* presented the specimens of two cases of PYOSALPINX, with interesting histories of the same.

*Dr. Olin Leech* said that the first case was under his professional care for two years prior to the operation, and he had insisted upon an operation being done for one year before consent was gained. She

had an attack of intermittent fever one year which ended in some gastric disturbance, and symptoms of ovaritis on the right side soon followed. Later she had symptoms of inflammation of the left ovary. Treatment from time to time relieved her temporarily, but after having first a localized peritonitis and then a general peritonitis he insisted upon an operation being performed because of the diagnosis of pus tubes and diseased ovaries having been made. There seemed to be a great disposition to the formation of pus in this patient, as after the operation a great deal of trouble was experienced by the formation of localized areas of pus in and near the abdomen. Recovery at last was complete.

*Dr. Stavely* said that these cases of pyosalpinx were unfortunately not rare. A case of considerable interest to him was one giving the history of intermittent hydrosalpinx which was subjected to an exploratory operation, but no disease of the tubes was found. The patient was a nervous one and must have exaggerated her symptoms.

*Dr. Glazebrook* spoke of his experience in the preservation of specimens with formal and stated that a two per cent. solution was found to be quite as efficacious as a ten per cent. solution in preserving the specimen and had the advantage of not irritating the nose and eyes as the stronger solution does.

*Dr. Mackall* presented a case of A TUMOR OF THE EYEBALL. (See page 201.)

*Dr. Baker* read the paper of the evening entitled CIRRHOTIC KIDNEY. (See page 199.)

*Dr. Snyder* opened the discussion. He said that one or two cases are all that he remembers of this disease in his own practice. The worst feature of cirrhotic kidney to his mind is its beginning as a chronic disease. The destructive process affecting first the cortical substance of the kidney, extends down between the pyramids, and on in an obscure way until dissolution of the organ is accomplished. The urine is abundant in amount, of low specific gravity, contains no albumen, and only after repeated examinations do we find hyaline casts.

Dropsy is the second characteristic symptom. Amaurosis is the third. Another symptom that is quite pathognomonic of cirrhotic kidneys is a condition of hypertrophy of the left side of the heart with dilatation and no valvular lesion. Coma and convulsions wind up the array of symptoms marking this most insidious disease. The treatment might be summed up as follows:—Rest, alkaline water and warm climate.

Dr. Sprigg said that the treatment interested the general practitioner. Climate, alkaline water and rest seem to him not adequate treatment for cirrhotic kidney. If one kidney remains healthy treatment may accomplish very much and prolong life. Use vapor baths, strengthen the heart, principally by hypodermic administration of strychnia, and improvement will follow in the majority of cases. He had a case in mind of a young woman 21 years of age, who came to him as an office patient, giving the history of violent headache, almost to the point of causing delirium. These attacks had been treated by morphia. Shortly after this office consultation he saw her in one of these attacks of headache. He gave hypodermic injections of morphia, one-third of a grain, until  $1\frac{3}{4}$  grains were given during the course of an afternoon and evening. Some time after headache had been relieved by this treatment, patient had convulsions, with paralysis of the muscles of respiration and cyanosis. Artificial respiration was used for 45 minutes, then gave  $\frac{1}{24}$  grain of sulphate of strychnia. Then Dr. Bowen assisted him by using electricity and it took two hours to make the patient breathe. During this time only six ounces of urine was voided. For twenty-four hours following she voided only ten ounces, which contained only three grammes of urea. Vapor baths and poultices were used to stimulate the action of the kidneys. He had never before seen a convolution of this character.

Dr. Bowen referred to the poultices spoken of by Dr. Sprigg, and cited the case of an old lady with cirrhotic kidney with whom any amount of diuretics caused no appreciable increase of urine,

but upon the application of hot poultices the secretion of urine increases from 6 to 24 ounces in 24 hours. The powdered leaves of digitalis sprinkled over the surface of the poultices rendered them more effective.

Dr. Clark thought these cases of cirrhotic kidney were quite interesting, because if you study them carefully you will see that every symptom obeys a mechanical law. The slow pulse with increased tension (and I have not heard this symptom mentioned in the discussion) is due to the increased tension caused by cardiac hypertrophy. It is only after repeated examinations of the urine that we may find casts. The increased amount of water secreted by the kidneys does not necessarily point to contracted kidney; we can have this symptom in other conditions. Examination of the urine for urea, and ascertaining the amount excreted in 24 hours, is the important point. The changes in the retina is another very prominent and important symptom.

Dr. Van Rensselaer cited a curious case which illustrated some of these symptoms. A man came into his office for the purpose of having his heart examined. He found it beating so rapidly that he could not count its pulsations; they ranged anywhere from 200 to 250 per minute. All that this patient complained of was the discomfort of a slight dyspnea. He was given  $\frac{5}{10}$  grain of trinitrine and 30 grains of sodium bromide, and after reclining for a time on a sofa, was much relieved. The following day he came to the office with a pulse of 38. The next day he came with the rapid pulse again, and this attack proved much more obstinate to relieve than the first one. Repeated examinations of this patient's urine showed a specific gravity of from 1008 to 1012 and a great many hyaline casts were found. This young man, although apparently quite healthy, had cirrhotic kidney.

Dr. Glazebrook said it was very important to diagnose this condition as early as possible, and it would seem that this ought not to be so difficult because the symptoms were so common.

He cited a case of sudden death of a man aged 40 years; he died in a convolution; there were only three things worthy of note in the autopsy. A hypertrophied and enormously distended bladder; hypertrophied heart, particularly left ventricle; the aorta was somewhat distended, but there were no valvular lesions. The kidneys were small, the renal veins were engorged; the kidneys were so small that he took them out for examination on account of their disproportion. This was undoubtedly a case of cirrhotic kidney.

*Dr. Norton* thought that the cases that come to the post-mortem examination to be diagnosed are often not observed on account of careless examination. Patients coming to us with slight symptoms are oftentimes not examined carefully enough. Albuminuric retinitis is a very uncertain symptom to go on, as it occurs late in the disease. In the case of the young lady patient of *Dr. Sprigg*, when so small a quantity of urine was observed, if hot vapor baths and pilocarpine were used, he thought it would have been more appropriate treatment than morphia. The best treatment for cirrhotic kidney is a puzzling question; the diet advocated by some is decried by others; some laud milk, others discard it. We have got to consider the possibility of both kidneys being affected, because it seldom occurs that one kidney is affected and the other perfectly healthy. One of the most interesting points in this connection is the consideration of the theory that many symptoms are due to the non-excretion of certain solids in the urine.

*Dr. Clayton* noticed that the acute uremia has not been spoken of in considering the treatment. In his hospital experience, pilocarpine, croton oil, hot baths by both hot air and steam, have been found efficacious remedies in this affection, but bleeding seems to have given more relief in the few cases in which he has observed its use than any other remedy.

*Dr. Sprigg* said that the diagnosis of cirrhosis in one kidney and a healthy condition of the other was made on the strength of the fact that the condition of

acute desquamation subsides, and left only symptoms of the chronic desquamation. He did not know what the condition was when he first saw the patient and he acknowledged that the treatment would have been better without morphia. He also gave atropia, which is contraindicated in this condition, but he gave but one injection principally because he thought the morphia might have been the cause of failure of respiration.

*Dr. Clark* spoke of albuminuric retinitis not being a constant symptom in cirrhotic kidney. The greatest amount of interference with vision is when involvement of the macula lutea occurs. Oculists are sometimes the first to diagnose cirrhotic kidney.

*Dr. Mackall* said that he agreed with *Dr. Clark* in all of his points, these views being in line with those held by *Dr. Osler*.

*Dr. Clark* said that he had not read *Dr. Osler's* article on this subject.

*Dr. Stavely* had seen two cases of catheterization of the ureters in hematuria for the purpose of isolating the kidneys but nothing was determined thereby.

*Dr. Van Rensselaer* had seen a number of cases of uremic convulsions in drunkards brought to one of the emergency hospitals of New York City. Bleeding them a pint or quart and then using the saline solution by infusion in twice the quantity of the blood extracted proved very successful treatment. This treatment was suggested by a surgeon who had spent some time in the hospitals of Vienna.

*Dr. Baker*, in closing the discussion, said that in *Dr. Sprigg's* case if there was a cirrhosis of the kidney, there must have been cirrhosis of both kidneys and an acute nephritis occurred. As to the treatment of the uremic conditions the best results follow the use of hot baths, the only objection to them being that the convulsions seem to occur more frequently for a time under their use, pilocarpine, and probably morphia, to control convulsions. Keep the skin doing the work of the kidneys if possible.

Adjournment.

R. T. HOLDEN, M. D., Secretary.

## Medical Progress.

**IRON AS FOOD AND DRUG.**—Stockman has made some fresh estimations of the amount of iron in various ordinary diets (*British Medical Journal*). He found that the quantity of iron in the ordinary daily diet of healthy persons with good appetite averaged from 8 to 10 or 11 mg. a day (about  $\frac{1}{6}$  gr.). The convalescent diet of the Edinburgh Royal Infirmary, a sufficient maintenance for persons leading a somewhat inactive life, contained 6 mg. a day. In the diet of a young lady living in the ordinary way and taking an average amount of food, 8 mg. was found in the daily diet, while in that of two chlorotic girls who ate very little, the quantity of iron averaged 2.6 mg. a day (four estimations). From a consideration of the amount of iron in ordinary diets, Stockman is led to observe that the iron metabolism of the body must be small. Very little can be excreted, and the great bulk must be retained in the body and used over and over again. The total excreted daily by all channels is, he concludes, less than 6 mg. a day. When the red blood corpuscles break down, although their pigment is to a large extent excreted in the urine and bile, a large part of their iron must be retained in the liver and spleen, where it is gradually used for the formation of new red corpuscles.—Quincke observed at the last German Medical Congress that the amount of iron in the preparations in ordinary use was often forgotten, and he gives a table showing the percentage of iron in a large number of German official and unofficial preparations. Thus the citrate of iron and ammonia contains 1 gr. of iron in 6 gr. of the salt. The liquor ferri perchloridi of the British Pharmacopeia contains 1 gr. in  $\eta$  xx. When it is desired to promote the absorption of iron, Quincke considers it important that the iron preparation chosen should be in a very diluted solution when it comes into contact with the gastric mucous membrane; this end may be attained either by giving the drug with food or freely diluted. He recommended the administration of iron by subcuta-

neous injection in cases of anemia in which gastralgia or other gastric or intestinal disturbance placed difficulties in the way of the administration of most iron preparations by the mouth. He uses a 5 per cent. solution of citrate of iron; it produces very little local reaction and is quickly absorbed. He gives in this way from  $\frac{3}{4}$  to  $1\frac{1}{2}$  gr. daily ( $\eta$  xv to xxx). Liquor ferri peptonati (Denayer) is also very little irritating when injected hypodermically, and is of about the same strength in iron as the 5 per cent. solution of the citrate. The ammonio-citrate should not be used as it is very much more irritating than the citrate.

\* \*

**DENTISTRY AND GENERAL MEDICINE.**—However much American dentists may differ concerning the practice of dentistry and its relation to general medicine, says G. H. Chance, D. D. S., of Portland, Oregon, in the *American Journal of Dental Science*, medical men, with few exceptions, believe dentistry is a mechanical art only, and that dentists are mechanical craftsmen, and as such are not entitled to professional recognition from medical men. It will, therefore, be the purpose of this paper to show, if possible, that whatever may have been the dentistry of the past, the dentistry of the present is both a science and an art, as well as a liberal profession.

Modern dentistry is, in the broadest sense, both a science and an art. As a science, it deals with a full and an accurate knowledge of the dental organs and their functions, as well as with a knowledge of the causes leading to their pathological conditions whereby disease is engendered, and function either impaired or destroyed.

As an art, its votaries are instructed in and made acquainted with the various methods and means for combating dental and oral disease, that health may return and, wherever possible, function restored; so that it is quite safe to say that dentistry is science applied to dental and oral surgery. And it is quite as safe to say that medicine, when stripped of its scientific adjuncts, major and minor sur-

gery, is largely a system of guessing at probabilities in disease, with a fearful lack of harmony existing among the guessers, divided as they are into bellicose camps, some large and "regular," and some large and "irregular," besides other small camps of various construction, with guessing schools attached to each camp, teaching different theories, and each claiming to teach the only true Simon-pure method of guessing and of practice. And these, forsooth, are they who assume to write and publish their guessing criticisms on the dentist and his methods; one of these from the large and "regular" camp gravely guesses that dentists are not sufficiently sterilized to prevent infection from syphilitic patients when they apply to the dentist for treatment of the oral cavity.

Then there is the brother from the "irregular" camp of guessers, and he guesses that dentists ought not, under any circumstances, use amalgam for filling cavities in defective teeth, because he guesses that the potency of the dynamic force of his fifteenth dilution of the medicinal dynamo will be destroyed by coming in contact with the wandering mercurial spooks, which he guesses may inadvertently escape from between the meshes of the amalgam plugs. But surely we are not as ignorant as some of these guessers take us to be, and really do know more about some things than they give us credit for.

Dentistry has discovered the cause, and is daily successfully treating 90 per cent. of all the cases of so-called "facial neuralgia," whose victims apply to the dentist for relief. It has also vastly improved on the methods formerly in vogue by the medical profession for the surgical treatment of tumors of the oral cavity, as well as fractures of the jaws, simple or compound. It has aided and abetted the aurist and oculist in their efforts to restore function. It was a dentist who first thought out and who first put to practical use that boon of boons, anesthesia, and who gave his experience to the medical profession and to the world without fee or reward. What has here been stated as standing

to the credit of dentistry is but a tithe of what it has accomplished, and is destined to yet accomplish in the interest of suffering humanity, in spite of adverse medical criticism.

The "medicine man," whose office was in former ages merged with that of the priest and prophet, and who also was thought by many to be gifted with supernatural powers in the art of healing the sick, has from time immemorial exerted a seeming mysterious influence over the minds of the common people, sometimes for good, sometimes for evil; and this seemingly strange influence exists in the minds of the laity today; hence the physician's opinion, when he is called to the sick-room, is deferred to in all cases almost without question; and to a certain extent this is right, for such confidence enables the conscientious, competent physician to treat the patient according to the exigency of the case, free from the ignorant interferences of anxious friends. Besides this, very few of the laity possess any genuine knowledge of the *mysteries of medicine* so that there are obvious reasons for this sometimes "blind faith" in the chosen physician, no matter from what school he may come.

Such things show us how very differently the physician and the dentist are held in public estimation; the services of the former being sought mainly for his supposed skill in the mysteries of medicine, while the latter is employed not so much for his technical knowledge, which, of course, he must possess, as for the special labor he is expected to perform; so that to succeed in our calling it is not necessary that we should wear the badge of medical servitude, for dentistry is the product of a higher and more advanced form of civilization, a scientific, independent profession, developed by master minds of a more recent generation, and not a *medical legacy* left us from a former period, when the medicine man was the only source to whom suffering humanity was taught to look for physical relief, and whose application was in vain when the malady was of dental origin.

Dentistry, like general medicine, is

here to stay ; both are needed, and both are without doubt intended as instruments in the hands of the properly educated for the relief of physical suffering; and so far as scientifically educated, limited human foresight can go, are also intended to be used for the *prevention of disease*, but such desired results can be reached in certain cases only in proportion as physician and dentist are willing to consult and coöperate with each other; and to do this intelligently and successfully each must possess that kind of an education which will not only fit him for practice in his own field, but must, to a considerable extent, overlap other branches of the healing art. While it may not take in all details, neither does such an education imply that a dentist shall practice general medicine, or the physician dental surgery.

This is precisely the kind of education the dental students acquire in the dental colleges of today ; three full years of study and attendance on three full courses of lectures being required before the student can be graduated. It will be noticed that the time required to be graduated in dentistry is the same as that required for graduation in general medicine. It will, therefore, appear to the observant mind, that if it takes three years to graduate a student in dentistry, and no more than three years to graduate a student in general medicine, that there must be something more to learn in dentistry than the average physician, with his present limited knowledge of the dental organs, is prepared to admit. The medical man should, if only for his own reputation, be better informed on the subject of the teeth than is the average physician of today, the teaching of which has been sadly neglected in the medical colleges.

\* \* \*

**A NEW METHOD OF ESTIMATING ALBUMEN IN URINE.** — Riegler (*British Medical Journal*) brings forward a new and rapid method of estimating albumen by means of the refractometer. It depends upon the power of his new reagent, asaprol, to precipitate all albuminous substances, in acid solution ; the precipitate is soluble in weak caustic

soda or potash, and the refractive index of the solution bears a direct relation to the amount of albumen present. In practice the asaprol (10 per cent.) is made up with 10 per cent. concentrated hydrochloric acid. Exactly 25 c.cm. of deci-normal potash solution are used and added to the precipitate resulting from the mixture of 5 c.cm. of asaprol solution with 50 c.cm. of urine. The refractive indices of the resulting fluid (after filtration) and of the potash solution are determined by Pulfrich's refractometer, and their difference divided by 270 gives the exact percentage of albumen present. The coefficient 270 was determined by Riegler as the result of experiments on measured quantities of albumen.

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**SODIUM NITRATE SUBCUTANEOUSLY IN SYPHILIS.** — Having ascertained that the nitrites possessed microbicidal properties, says M. Petrone in the *American Medico-Surgical Bulletin*, the author conceived the idea of trying sodium nitrite hypodermatically as an antisyphilitic.

In the two cases of syphilis in which he employed this treatment, he obtained remarkable results.

The first case was that of a robust man suffering with a relapse of syphilis. There were violent osteocopic pains, multiple periostosis of the cranium and of the tibiae, and an extensive papulopustular eruption over the body. Besides this, the patient had been troubled with malarial cachexia for several years. His spleen was of enormous size, his complexion sallow, and he had frequent attacks of fever of an irregular type.

Dr. Petrone made daily subcutaneous injections of sodium nitrite, beginning with 0.05 gme. ( $\frac{3}{4}$  grn.) doses, but quickly increasing them to 0.5 gme. ( $7\frac{1}{2}$  grn.). This dose, which was injected in two portions in the course of the day, was always well borne.

Under the influence of this treatment, the pains diminished with such rapidity that, after the second injection, the patient was able to sleep quietly.

The periostosis as well as the eruption decreased quickly, and finally disappeared completely ; at the same time,

the general health improved, and the spleen became reduced to one-third its former size. At the end of one month the patient was considered cured.

The second case the author treated by this method was that of a girl with hereditary syphilis. The trunk and the region of the left greater trochanter presented several gummata, some of which were in a state of softening, and there existed on the left leg a large ulcer which extended nearly around that member. The injections were made, as in the case mentioned above; the daily dose being rapidly brought up to 0.5 gme. (8 grn.).

It is reported that, after one month of this treatment, the gummata had disappeared, and the ulcers of the leg were completely healed. No other local treatment was employed, save a simple wash of boric acid to subdue the fetid odor arising from the ulcer.

Dr. Petrone says that the solutions of sodium nitrite destined for hypodermic use should not contain more than 2 to 3 per cent. of the salt; more concentrated solutions are painful.

Abscesses were never formed at the point of injection.

\* \* \*

**CONDITION OF THE BLOOD IN PURPURA.**—In the *Lancet* is an essay on purpura hemorrhagica by Professor Hayem, in which the condition of the blood in this disease is recorded, and describing investigations made by him, Professor Hayem states that in this variety of purpura the blood possesses the following characteristics: 1. There are no appreciable anatomical modifications in the red corpuscles, except, perhaps, a diminution or absence of those corpuscles of exudation which are produced by the disintegration of the red cells when preparations of blood are submitted to the action of solvents. 2. There is a considerable diminution in the number of hematoblasts; those that remain are often considerably increased in size. 3. There is no constant alteration in the number of leucocytes. In one case only was the number of white cells increased. 4. The coagubility of the blood was normal. The fibrous ret-

iculum remained invisible, although, on the other hand, it was formed of fibers of an unusually large size. 5. Transudation of serum was absent from the clot, which latter possessed only a feeble power of contraction. Thus, the two characteristic and constant pathogenic properties of the blood appeared to be the scarcity of hematoblasts and the absence of transudation of serum after coagulation. The diminution of the hematoblasts in purpura would partially explain the production of hemorrhages (epistaxis, menorrhagia, etc.), as these bodies play an important rôle in the arrest of bleeding and the clotting of the blood. It is probable that in certain diseases attended with purpura the diminution in the number of hematoblasts is in consequence of a destruction of these elements. It is possible that the state of the blood may be dependent upon a faulty elaboration of nutrient material, or upon the introduction into the blood, under the influence of digestive disorders, of toxic substances having the property of producing changes in the hematoblasts.

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**A NEW FORM OF REACTION OF DEGENERATION.**—The *Revue internationale de médecine et de chirurgie pratiques* for November 25 contains an abstract of a paper quoted in the *New York Medical Journal*, which was read by Dr. Ghilarducci at the recent congress of the Italian Society of Internal Medicine. The study of electric reaction in twenty-two cases of atrophic paralysis, says the writer, enabled Dr. Ghilarducci to formulate the following conclusions: We may affirm the existence of a new form of reaction of degeneration—namely, reaction at a distance. This reaction is characterized by contractions which manifest themselves in the degenerated muscles when the circuit is shut off, and in applying the electrodes at a distance from the muscle, and in such a position that the muscle will be included in the intervening space. This form coexists constantly with the classical reaction of degeneration. The reaction at a distance depends very probably on a slackening of the electric wave, which is due appa-

rently to the conditions under which the experiment is made. The reaction at a distance persists for months and years when the electric excitability elicited by the classical method has completely disappeared in the nervous trunk and in the muscles.

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**THE NECESSITY OF FREQUENT VISITS.**—The Supreme Court of California, says the *Medical Record*, in an action brought by a physician for professional services—the defence being that the visits were too frequent and not necessary—rules that “The defendant having admitted the employment of the plaintiff as a physician to treat his wife and children, the plaintiff was the proper judge of the necessity of frequent visits and in the absence of proof to the contrary the Court will presume that all the professional visits made were deemed necessary and were properly made. It would be a dangerous doctrine for the sick to require a physician to be able to prove the necessity of each visit before he can recover for his services. This is necessarily a matter of judgment, and one concerning which no one save the attending physician can decide. It depends not only upon the condition of the patient, but in some degree upon the course of treatment adopted.”

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**CARDIAC THERAPEUTICS.**—One of the most powerful cardiac stimulants is strychnia. Dr. Wm. C. Krauss says in the *Therapeutic Gazette* that it strengthens the heart directly through the vagi, indirectly through improved muscular tonicity, the result of increased activity of the digestive organs.

Strychnia is especially indicated in the weak heart of pneumonia and the febrile processes generally. It should be given hypodermically in  $\frac{1}{60}$  to  $\frac{1}{60}$  grain doses, repeated until some sign of the action of the drug is manifested. It is useful in chloroform poisoning, in surgical shock.

Strophanthus is another rival of digitalis. In the progressive heart failure of old people it acts well; in angina pectoris and in tachycardia. In asthma it acts on the unimpaired cardiac muscle.

Parenchymatous nephritis is benefited by it. As a cardiac sedative in exophthalmic goiter it is especially useful.

These two drugs, strychnia and strophanthus, will probably retain their supremacy in cardiac therapeutics.

\* \*

**THE TRANSMISSION OF SCARLET FEVER.**—Grasset (*Archives of Pediatrics*) reports that a child visiting away from home was taken ill with scarlet fever; the friends remarking that the desquamation was like the casting of a snake skin, wrote a description and enclosed three pieces of skin for the parents. Six and a half days after receipt of the letter, a baby brother of the first child, living at home, took the disease.

The only other case of transmission of contagion by letter reported was published by Sanné. In this case two persons received a note from a convalescent from scarlet fever, who wrote that she was desquamating so freely that she had to brush the fine scales off the note-paper on which she wrote. Some days later both recipients became ill with the disease. Physicians should warn their patients against such dangerous errors.

\* \*

**A TEST FOR INCIPENT DIABETES.**—Prof. v. Noorden, in the *Medical Record*, says he has discovered a new means of diagnosing diabetes in its very earliest stage, or even a hereditary tendency thereto. He gives the patient 100 grains of grape-sugar, which, in the normal subject, has no effect, but in the incipient diabetic produces glycosuria. If this prove correct it will be most useful in gaining for the diabetic the earliest possible treatment with the best prospects for a cure.

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**CHILLS IN TYPHOID FEVER.**—Dr. William Osler calls attention in the *University Medical Magazine* to the occurrence of chills both at the onset and during the attack of typhoid fever and cites a number of cases tending to illustrate his point showing that the malarial cause of these chills was absent although the chills were intermittent in character.

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BALTIMORE, JANUARY 4, 1896.

REFERENCE was made not long since to the recent political upheaval in Maryland in consequence of which there

**Political Positions** for **Physicians**. is every probability that

many changes in office will be made. In these

changes some positions will be given to physicians either on account of their especial fitness or through some influence with the appointing powers.

The interest in all city and State positions has caused the publication of several little books, giving a list of all public offices with their remunerations. No clue is given to the kind or amount of work which will be demanded in return for this remuneration, still it may be of interest to physicians to know exactly what these places are and what the pay in connection with them is.

All of these places are for Baltimore physicians only, and the local positions in the counties are probably known to the physicians living in the various parts of the State.

The city positions are the gift of the Mayor and City Council, and the State appointments are made by the Governor and the Legislature.

## CITY.

**Bay View:** Four Resident Physicians, each \$500.

**Health Department:** One Commissioner, \$3000; One Assistant Commissioner, \$2000; One Medical Examiner, \$1000; One Assistant Medical Examiner, \$500; The Sanitary Inspectors, of whom there are eleven, receive from \$800 to \$1000 apiece.

**Vaccine Physicians:** Sixteen, each \$300, and six with station house duty, each \$400.

**Jail:** One Physician, \$1500.

**Marine Hospital:** One Physician, \$3000; One Assistant Physician, \$1000.

## STATE.

**Police Board:** Three Examining Physicians, each \$1000.

**Maryland Penitentiary:** One Physician, \$1500.

**Spring Grove Asylum:** One Medical Superintendent, \$3000; Three Assistant Medical Superintendents, each \$800.

**House of Correction:** One Physician, \$600.

**Coroners:** Seven coroners for Baltimore City, each \$1000.

**State Board of Health:** One Secretary, \$2000.

**Vaccine Agent:** One State Vaccine Agent, \$800.

In looking over this list it may be noted that the resident physicians at Bay View Hospital are usually named by the faculties of the Baltimore Medical Schools. In the Health Department it is very likely that the present incumbent will be retained. It is the desire of the Health Commissioner to have as sanitary inspectors young physicians for investigating the contagious diseases and non-medical men for the nuisances. As it stands now all are non-professional men and are usually very ignorant ones at that. The city may congratulate itself that the medical examiner has been reappointed and will be retained.

In the State a change is not likely, nor is it desirable to make one, in the Medical Superintendent at Spring Grove Asylum. The other positions will probably be looked into carefully and some necessary changes will be made. Of course the minor positions will

not be accepted nor will they be desired by men of any great attainments, but the higher positions demand men with some ability and fitness for their respective places and the profession of the State should take sufficient interest to make a demand for the right men to represent them.

There is plenty of poor medical material ready to serve the city and State. These positions are all important ones and every physician should lay aside his apathy and pick out his candidate and act for the best interests of the city and State.

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**STATISTICS** figure so largely in all reports and are made use of to such an extent to prove almost anything the *Crude Statistics*.

writer has in view that it behooves one to accept with caution proofs founded on the statistics of the hobby rider. Take, for example, the death rate and birth rate of any community.

The *Hospital* of London points out the false deductions which may be drawn from a low rate of mortality in one year. The influence of a rising or falling birth rate must always be considered when the death rate is mentioned. In some communities where there is a decreasing birth rate and the number of children is small, the effect is to diminish the proportion of young children in the population, and thus lower the mortality, for the death rate of children under five years of age is greater than at any subsequent period of life up to sixty-five years of age.

Crude statistics may lead one to believe that the death rate is lessening year by year and that persons are living to a greater age than formerly, when in reality this lessened death rate is due to a small infantile population and has no connection with possible improved sanitary conditions.

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**THE** fact that persons not infrequently feign illness to obtain board and lodging in a hospital has made the average *Malingering*. hospital physician very susceptible of sudden attacks and certain vague ailments. Physicians to jails, reformatories and penitentiaries find that the inmates are very willing to shirk work if they can pretend to be ill.

It was lately discovered that in one such institution where reading was allowed, that the

most carefully read book was one on medicine which the more intelligent inmates thoroughly perused in order to become acquainted with the more prominent symptoms of the diseases which would exempt them from duty and work.

One favorite disease is locomotor ataxia and in some hospitals where frequent clinical lectures are held over what is called a good case, the patient, even when not very intelligent, soon learns to know the symptoms which ought to show themselves and brings them forward and even exaggerates them, much to the instruction of the students.

The hospitals are always full in cold weather and many a poor man delights in the prospect of a comfortable bed, good food and a life of idleness, with plenty of attention from trained nurses. Malingeringers do harm to innocent persons who arouse the suspicion of the physician and may even be turned out of hospital when they are deserving.

The use of an anesthetic will often bring out the truth. In one case where a feigned sprain of one hand was made, the surgeon used ether, holding the well hand, and in a few minutes the helpless hand reached up and grasped the ether cone and the discovered malingeringer walked out of the hospital, probably only to repeat his trick before a less clever surgeon.

A physician or surgeon who makes a snap diagnosis and reveals the true character of a malingeringer receives great praise and applause from his students, but too often such a bold stroke will fail, for the expert malingeringer is practiced and is ready for any emergency and every surprise. Malingeringers usually do no great harm, but they should be dealt with summarily whenever discovered.

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**THE** State Board of Health is required by the Michigan Legislature to send to public school superintendents

**Sanitary Education.** and teachers throughout the State printed data and statements which shall be used by them in teaching their pupils the modes by which the dangerous communicable diseases are spread, and the best methods for their restriction and prevention. A regular campaign of education has for many years been carried on by lectures and the distribution of pamphlets, leaflets, tracts, etc.

**MEDICAL ITEMS.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending December 28, 1895.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		25
Phthisis Pulmonalis.....		27
Measles.....	131	5
Whooping Cough.....	6	1
Pseudo-membranous Croup and Diphtheria.	9	6
Mumps.....	1	
Scarlet fever.....	8	
Varioloid.....		
Varicella.....	1	
Typhoid fever.....	2	3

A hospital for poor consumptives is in process of erection at Davos, Switzerland.

Dr. Charles S. Wegeforth has been appointed inspector of drains for the Health Department of Baltimore.

The Medical Society of the State of New York will hold its ninetieth annual meeting at Albany, January 28, 29 and 30, 1896.

Sir Henry Thompson of London has inherited property to the value of a half million dollars from a relative who was his patient.

Dr. J. J. Weaver, Sr., a prominent physician of Westminster, died in that place last week in the seventy-fourth year of his age. Dr. Weaver was a graduate of Jefferson Medical College, Philadelphia.

The New York Legislature will be asked this year to pass a law by which the right to give medical expert testimony will be lodged in a non-partisan board appointed by the Governor and approved by the Senate. No physician not a member of the board will be allowed to testify in any of the courts of that State unless it be upon the absolute facts of the trial. Any such expert may, however, appear before the board and give evidence.

M. Leroy Beaulieu of Paris states, in the *British Medical Journal*, that civilization with its results of education and comfortable living weakens the prolific power of nations. The degree of civilization attained by a nation can be estimated by studying its birth rate. Italy is the only exception to this rule; the percentage of births does not decrease in that

country, it is 37 per mille. The antidote to this evil is furnished by the fact that civilization brings with it better sanitation; the mortality is less and the average span of life is greater.

The date of the Twelfth International Medical Congress, to be held in Moscow, has now been definitely fixed for the week August 19-26, 1897 — cholera and the state of the political atmosphere permitting. The Czar has signed the Imperial Rescript sanctioning the Congress, and his Majesty's uncle, the Grand Duke Sergi, Governor-General of Moscow, has consented to be its patron. The President will probably be Professor Klein, Dean of the Medical Faculty of Moscow University; Professor Erisman, Professor of Hygiene in the same University, will be General Secretary. The Russian Government has granted a subvention of 120,000 francs (\$24,000) towards the expenses of the Congress. The official languages of the Congress will be French and German.

George Keil, editor, of Philadelphia, announces the early publication (fourth edition) of "Keil's Medical, Pharmaceutical and Dental Register Directory and Intelligencer," for Pennsylvania, New York, New Jersey, Maryland, Delaware and District of Columbia. Its list of National colleges, State hospitals, homes, dispensaries, societies and post-office addresses of physicians, druggists and dentists, school of graduation and year, all the latest laws in these States, will be complete to date of issue as a personal canvass will be made for data. It is the only Directory published for above named States, registering graduates of all schools, physicians, druggists and dentists, and imparting all information needed by the professions mentioned in their daily practice. No effort will be spared to make the Directory complete, and the information accurate and reliable in the minutest detail belonging to the domain of medical, pharmaceutical and dental professions. An experience of thirty years is a sufficient guarantee that all subjects will be properly treated in Keil's Directory. The names in large cities, in addition to being in alphabetical order, will be numerically arranged by streets, also an alphabetical list of names of the whole Directory, giving the page of each; these features will no doubt be appreciated.

## WASHINGTON NOTES.

The weekly report from the Health Office is as follows: Total number of deaths 103; white 61; colored 42. Death rate per 1000 for whites 16.9; for colored 24.8; total 19.4. Corresponding death rate for this time last year 15.7. There is slight improvement in the death rate over last week. The number of deaths from diphtheria 2; from scarlet fever 1; from typhoid fever 8 and from malarial fever 1. The number of white births 66; colored 43. Total 109.

Dr. F. R. Hagan, who has just completed an interne's service at the Children's Hospital, has been appointed on Dr. Halsted's staff at the Johns Hopkins Hospital in Baltimore.

Dr. H. L. E. Johnson, gynecologist to the Emergency Hospital, removed an endogenous cyst a few days since, which was larger than a full term pregnancy and must have weighed between 30 and 40 pounds. It was gelatinous and of firm consistency and it was really amusing to see one handful after the other pulled out until two large basins were filled. The woman is doing splendidly.

Dr. James Kerr has apparently, at least so far, cured a case of traumatic epilepsy. A jockey, one year ago, was thrown from his horse and fractured the skull, just over the left parietal eminence. Since that time he has been having epileptic seizures numbering sometimes two or three a day. The attacks were ushered in by violent jerkings of the right hand and foot. One month ago he was trephined, depressed bones removed and a considerable portion of evidently diseased convolutions pared off. There was very profuse hemorrhage and it was feared that he would die from that but he recovered and has had no attacks and no twitching even of his right hand or foot. Dr. Kerr is to be congratulated on the success of this case.

## Book Reviews.

TWENTIETH CENTURY PRACTICE. An International Encyclopedia of Modern Medical Science. By Leading Authorities of Europe and America. Edited by Thomas L. Stedman, M. D., New York City. In Twenty Volumes. Volume IV. Diseases of the Vascular System and Thyroid Gland. New York: William Wood and Company. 1895.

The fourth volume of this valuable system of medicine has just appeared. Dr. Whitta-

ker's contribution on diseases of the heart and pericardium is very comprehensive and well done. He includes the natural methods of treating heart disease by rest, proper diet and exercise. Some clinicians may find fault with the statement that the presystolic murmur is heard most distinctly at the apex; it is usually above the apex. He finds insufficiency and stenosis of the mitral valve most usually conjoined. A double basic murmur is common but a double mitral murmur is rare. He does not give digitalis in aortic valve troubles. He does not think much of digitoxine. The other chapters in the volume are excellent and all up-to-date, especially that on the thyroid gland.

A MANUAL OF SYPHILIS AND THE VENEREAL DISEASES. By James Nevins Hyde, A. M., M. D., Professor of Skin and Venereal Diseases, Rush Medical College, etc., Chicago, and Frank H. Montgomery, M. D., Lecturer on Dermatology and Genito-urinary Diseases, and Chief Assistant to the Clinic for Skin and Venereal Diseases, Rush Medical College, etc. With Forty-four Illustrations in the Text and Eight Full-page Plates in Colors and Tints. Philadelphia: W. B. Saunders, 1895. Pp. 8-17 to 618. Price \$2.50.

This manual of 600 pages has been written to meet the special needs of the student and practitioner rather than the expert, and therefore all points of controversy have been excluded. This work is eminently fitted for the purpose designed by its authors and one cannot commend too highly the excellence of the illustrations and plates. With reference first to the section on Syphilis, to which half the book is devoted, we can detect at once the master hand of Dr. Hyde, who has here promulgated many good broad and practical views on this very important subject. The clear, concise and accurate descriptions of the multiform lesions of this disease will prove of great help to the physician. We have been so used to the "primary," "secondary" and "tertiary" stages given by all the later syphilographers, that it is refreshing to read here of a division which one must acknowledge is more met with in actual practice.

The divisions are: 1. Benignant syphilis with mild and transitory symptoms. 2. Benignant syphilis with relapsing and persistent superficial symptoms. 3. Malignant syphilis with relapsing or persistent profound symptoms. 4. Malignant syphilis with relaps-

ing or profound lesions that are ultimately destructive.

With many of the pathological descriptions, especially of the skin lesions, we do not at all agree and there is shown an entire lack of any originality. There is an excellent table showing the most striking differences between chancroid, syphilitic chancre, herpes progenitalis, etc. The remaining portion of the manual is devoted to chancroid, acute and chronic urethritis, etc., and these subjects have also been handled in a very able, concise and up-to-date manner. The manual can without doubt be highly recommended to both students and physicians.

**STIMSON'S OPERATIVE SURGERY.** New third Edition. A Manual of Operative Surgery. By Lewis A. Stimson, B. A., M. D., Professor of Clinical Surgery in the University of the City of New York. New (third) edition. In one royal 12mo. volume of 614 pages, with 306 illustrations. Cloth, \$3.75. Philadelphia: Lea Brothers & Co. 1895.

The former editions of this practical work have been reviewed in these columns. The present edition has been thoroughly revised and rewritten and many important additions have been made, the most noticeable of which are the chapters on the surgery of the cranium and abdomen. The volume is well printed, thoroughly and clearly illustrated and of a convenient size.

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#### REPRINTS, ETC., RECEIVED.

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Indications for Electrolysis in Angeioma and Goiter. By Charles E. Dickson, M. D., of Toronto.

A Series of Clinical Cases. By Charles A. Oliver, M. D., of Philadelphia. Reprint from *Wills Hospital Reports*.

Ante-Partum Ophthalmia Neonatorum (Intra-uterine Ophthalmia). By Harry Friedenwald, M. D. Reprint from the *Medical News*.

Sanitation in Street Pavement. By H. O. Marcy, A. M., M. D., LL.D., of Boston. Reprint from the *Journal of the American Medical Association*.

The Contagion, Mortality and Prevention of Whooping Cough. By William Sweemer of Milwaukee. Reprint from the *Transactions of the State Medical Society*.

The Treatment of the Second and Third Stages of Chronic Glandular Gastritis. By Fenton B. Turck, M. D., of Chicago. Reprint from the *Therapeutic Gazette*.

#### Current Editorial Comment.

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##### THE PHYSICIAN IN POLITICS.

*Medical Brief.*

EITHER through diffidence or press of work, few physicians have ever cared to enter the arena of politics or given much attention to the financial policy of the nation. In view, however, of the fact that the welfare of each class depends upon that of all others, that our prosperity as a nation depends upon a rational financial system, we think the American physician, born educator that he is, should give more consideration to the health of the great body politic.

##### HOSPITAL FOR CONSUMPTIVES.

*Philadelphia Polyclinic.*

THE great argument in favor of separate hospitals for consumptives is not that such cases when admitted to general hospitals are a source of danger to others, but that few hospitals in which acute cases are treated possess a sufficiently numerous staff of nurses and resident physicians to give patients with pulmonary tuberculosis the constant attention needed, and fewer still are equipped with the appliances necessary for the proper treatment of the disease. Experience, too, has shown that consumptives do better in special hospitals.

##### MEDICAL JOURNALS.

*Tri-State Medical Journal.*

WE wish once again to warn our subscribers and advertising patrons against bogus medical journals and fakir journalism. We do not refer so much to the few new journals, which, like mushrooms, spring up at this season and last for a day, but we wish to protest against the support which doctors and advertisers give to Munchausen sheets. Many of these snide journals are started by job printers, advertising agents, and other irresponsible parties, who cover their teeth and wolfskin hair with the decent cloak of medical journalism. Such men are often not content with skinning advertisers by one medium alone; they buy or establish another journal or two, and like leeches suck the life-blood of their victims. Often the names of a score or more of doctors will adorn the front page—ignorant decoys that they are. We have always said, and we repeat it now: medical journals should be owned by medical men.

# MARYLAND MEDICAL JOURNAL

A Weekly Journal of Medicine and Surgery.

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## Original Articles.

### THE AMERICAN MEDICAL COLLEGE ASSOCIATION; ITS ORIGIN, DEVELOPMENT AND PRESENT STATUS.

READ BEFORE THE MEDICAL SOCIETY OF THE WOMAN'S MEDICAL COLLEGE,  
NOVEMBER 5, 1895.

By Eugene F. Cordell, M. D.,

Professor of the Principles and Practice of Medicine, Woman's Medical College, Baltimore.

Six years ago the status of medical education in this city was such as might well have brought a blush to the cheeks of every Baltimore physician who was not too much blinded by personal interest to appreciate our shortcomings. The schools had multiplied and keen competition for students and fees had opened wide their portals to all comers without regard to their antecedents or consequents.

It is my honest belief that within a few years it was possible for a student to matriculate and even graduate here without knowing how to read and write. Two short sessions, the duration of which might be still further reduced by the laxity of the rules regarding attendance, two unvarying courses of lectures, the omission of important branches, the entire absence of laboratory instruction and the farcical final examinations were the most glaring defects in the system then in vogue.

The address of Dr. Richard H. Lewis of Raleigh, N. C., before the Alumni Association of the University of Maryland in the Spring of 1889 (*MARYLAND MEDICAL JOURNAL*, April 13 and June 22, 1889, and *North Carolina Medical Journal*, XXIII, 1889), gave the first notable

impulse to the question of higher medical education in this community and we were still further impressed by the stirring oration of Professor Osler, a few weeks later, at the meeting of the Medical and Chirurgical Faculty of Maryland (*Idem*, May 25, 1889).

That the interest thus aroused might not be allowed to die out without results the writer personally interviewed members of the faculties of the several medical schools here with the object of eliciting their views upon the subject and securing some joint action upon their part. The gentlemen approached in general expressed themselves in favor of the plan and promised to bring the subject to the attention of their faculties so that, if approved, representatives might be appointed to a meeting of conference (*Idem*, May 4, 1889, page 4). The writer continued to agitate the matter during the summer and fall (*Idem*, July 20, 1889), but encountered much indifference. He was convinced that something further must be done to secure any effective action. It then occurred to him that if a petition were gotten up endorsed by a large number of the most influential members of the profession, especially those not connected with the

schools, urging the schools to take joint action, the desired results might be attained.

Accordingly the following paper was placed in circulation and having obtained ninety-six signatures, was sent to the various deans :

BALTIMORE, DECEMBER 17, 1889.

*Dear Doctor:* With a view to joint action on the part of our five medical schools, it is proposed to hold a meeting of representatives from the faculties, to discuss the feasibility of introducing reforms. It is thought that a joint action will render the difficulties to be met easier to deal with, and it is hoped that your interest in higher medical education will induce you to bring the matter before your faculty at the earliest practicable moment with a view to the appointment of a committee of conference. January 15, 1 P. M., and the hall of the Medical and Chirurgical Faculty of Maryland are named as the time and place of the meeting.

Yours respectfully, etc.

A few refused to sign this paper, although in general signatures were readily obtained. Many, however, expressed the opinion that my effort was a mere waste of time. An ex-president of the Medical and Chirurgical Faculty encouraged me to continue by saying that some good might result from agitation. Another ex-president, a prominent physician on Eutaw Place, who later gave his adhesion to the movement, refused to sign and said that we did not need any reforms here, that the school to which he belonged gave as complete an education as was desired, etc.

A prominent surgeon, who has been since a president of the Medical and Chirurgical Faculty, signed but wrote thus discouragingly : " You can never do any good by such papers ! So long as medical schools are financial ventures on the part of their faculties, just so long will they be as so many in this country. Conventions of medical schools have been so far as I can see useless. I went all the way to Atlanta to attend one once and it was a first-class farce."

The Dean of the University of Maryland replied to the petition under date

of December 18, 1889, that the faculty of that institution had already and independently adopted the needed reforms without waiting any conference of the schools and therefore declined to appoint delegates, etc.

At the date appointed, January 15, 1890, the meeting was held at the rooms of the Medical and Chirurgical Faculty, there being present Professors Streett, Merrick and Blake representing the Baltimore Medical College ; Professor Biedler representing the Baltimore University ; and myself from the Woman's Medical College. After some discussion, owing to the absence of delegates from other schools, a postponement was held until the following week. January 23, in addition to those above named, Professor Friedenwald appeared on behalf of the College of Physicians and Surgeons and Professor Evans as an additional delegate from the Baltimore University. Professor Friedenwald then announced that he was commissioned by his faculty to bring before the meeting a proposition for a national conference for the consideration of the reforms suggested in medical education and he named Nashville, Tenn., as the proper place and the next annual convention of the American Medical Association as the proper occasion for the conference. He added that his faculty did not regard it as feasible or expedient, but, on the contrary, suicidal, for the Baltimore schools or any one of them to take this action alone. This suggestion met with favor and the writer (who was secretary) was directed to prepare a circular to be sent to the colleges.

At a meeting held the next week, Professor Latimer of the College of Physicians and Surgeons, and Professors Thomas and Smith of the Woman's Medical College being also present, the proposed circular was presented by the Secretary and discussed. It was determined to submit it to a fuller meeting of all the faculties, and to write the staff of the Johns Hopkins Hospital to be present also. This meeting was held on February 6, Professor Hurd of the Johns Hopkins Hospital, Professors Walker and Ellis of the Baltimore Medical College

and Professors Wiley and Whiteford of the Baltimore University joining the other delegates. Professor Osler sent a letter of regret on account of his "unavoidable absence" and "sympathizing most heartily with the effort." Professor Hurd also expressed the hearty sympathy of the staff of the Johns Hopkins Hospital, but thought "we must look to the individual action of the schools rather than to any general action for results."

The circular was fully discussed, and after some slight verbal alterations was ordered to be sent to all the medical schools in the United States. It read as follows :

*To the Medical Colleges of the United States :*

The following Baltimore medical schools: University of Maryland, College of Physicians and Surgeons, Baltimore Medical College, Baltimore University, Woman's Medical College of Baltimore and the staff of the Johns Hopkins Hospital—having met for the consideration of reforms urgently needed in the system of medical education, hitherto in operation in this country, after a full discussion of this most important subject, have come to the conclusion that it is not expedient nor indeed practicable for the medical schools of any State alone to assume the responsibility of adopting advanced methods. Yet fully convinced of the pressing need of a change and earnestly desirous to see it consummated, they are unwilling to let matters rest longer as they are without at least an effort on their part to improve them. They have determined, therefore, to issue this appeal to the medical schools of the United States for their coöperation in inaugurating a *national advance*. Fully aware of previous ineffectual efforts in this direction, they yet realize that times have greatly changed since these efforts were made, and they believe that a repetition of them at this time would have a good prospect of success. The approaching meeting of the American Medical Association, drawing delegates as it will from every part of the country, offers a good opportunity for convening those who are interested in the contemplated changes. We therefore invite you to join with us in holding a conference for the full consideration of "medi-

cal education in this country and measures for its improvement," and we request that you will appoint, at your earliest convenience, one or more delegates from your faculty to represent it at a meeting to be held at Nashville, Tennessee, on the 21st of May, 1896, at 3 P. M. It is requested that delegates should be instructed, as far as possible, as regards the wishes of their faculties upon the various measures now proposed in connection with advances in medical instruction, in order that definite results may be arrived at with the least possible delay and trouble. The following subjects are considered as most likely to come up for discussion :

1. Three years' course of six months' sessions.

2. Graded curriculum.

3. Written and oral examinations.

4. Preliminary examination in English.

5. Laboratory instruction in chemistry, histology and pathology.

A. FRIEDENWALD, M. D., President,

EUGENE F. CORDELL, M. D., Secretary,  
On behalf of the Baltimore Faculties.

BALTIMORE, MARCH 20, 1890.

*Please notify Dr. Eugene F. Cordell, No. 2111 Maryland Avenue, Baltimore, Md., of the action you may take regarding this circular.*

At the next meeting, the University of Maryland, which had meanwhile affixed its signature to the circular, was represented in person by Professor I. Edmondson Atkinson.

With this measure the active work of the Baltimore Association came to an end, for although kept up ostensibly for some time longer, and although a few meetings were actually held with a view to establishing uniformity in the curriculum of the Baltimore colleges, no agreement was reached and finally it was dropped.

The circular was duly distributed and met with a most hearty and unexpected response. By the middle of May the writer was notified that of the 132 medical schools in the United States, 24 would send delegates to Nashville and 8 others regarded the plan with favor (*Idem*, May 17, 1890). The higher schools, however, as a rule, held aloof at first, doubtless from the idea that they had already adopted reforms equal

at least to those proposed in the conference and therefore did not need to confer upon the subject. This was a very narrow view and the writer did all he could to convince them of it. They ought rather to have felt that their position and example imposed upon them the greater responsibility and endeavored to use their influence for the general good. It was not a question of any limited and temporary advantage, but the opportunity was offered for reforming the whole system of medical education in this country.

The meeting for organization was held in the Senate Chamber of the Capitol building at Nashville, as announced, May 21, 1890, Professor Friedenwald presiding at the opening. A permanent organization was effected by the election of the venerable Dr. N. S. Davis as President and several Vice-Presidents. Forty-nine colleges were represented by sixty-seven delegates. The most important result achieved was the adoption of rules of government in the Association, to take effect in the fall of 1892. The second meeting of the Association was held in Washington City, May 4, 1891. At this meeting Professors Osler and Millard submitted a minimum of requirements for membership in the Association, which was adopted and made obligatory in the fall of 1892. This provided for three annual graded courses of lectures of not less than six months before graduation, for written and oral examinations, for preliminary examination in higher arithmetic, elementary algebra and physics, for composition and for translation of easy Latin prose. A year was allowed for complying with the last requirement. A judicial council was instituted, consisting of seven members.

The Latin requirement was vigorously contested, many colleges objecting to it, but the sentiment of the majority favored it and it was retained.

The third session was held at Detroit, June 8, 1892. Nothing special was then accomplished further than a discussion of certain subjects and the reading of some interesting papers. Up to this time 66 colleges had been represented

by delegates at the various meetings, but two of these had resigned membership. The list is conspicuous by the entire absence of the schools of New York City and of Virginia and by the paucity of those from the south. The schools of the northwest are represented in full force and it must be confessed that to their vigorous support and action are due the early success and high standard of the Association.

The following items are taken from the constitution of the Association adopted at this time: The conditions of membership are written application, an annual fee of \$5 and observance of the rules. All colleges are required to subject matriculants not otherwise exempt to examination in English composition, higher arithmetic, algebra, elementary physics and Latin prose. Students conditioned upon one or more of these branches are allowed a year to make up such deficiency, but failure at the end of the year precludes the applicant from further attendance. Graduates are required to be examined on all the subjects taught by the faculty of the college granting the degree, whether the candidate has spent his whole time in that institution or not. Three courses of graded instruction of not less than six months in separate years are required. These rules were to be enforced on all students matriculating on and after July 1, 1892. To the judicial council is assigned the duty of investigating and determining all questions of violation of the rules and regulations of the Association and all matters of dispute between its members.

This constitution remains in force to this day, except that clause relating to the period of study. At the meeting held in San Francisco in 1894, an amendment was adopted requiring of the colleges a four-year course beginning with the present session. This caused much unfavorable criticism and even threats of withdrawal. It was said that certain persons, whose enthusiasm outran their judgment, had taken advantage of a small meeting (23 in a total of 41 colleges) in a remote and inaccessible part of the country, to railroad the amend-

ment through ; that it was premature ; that it would be reconsidered the next year when there would be a fuller representation and be then undoubtedly rescinded. But at the next annual meeting (that held in this city last May) the legality of the San Francisco meeting was maintained and a motion to postpone the introduction of the four-year term submitted by the Dean of the College of Physicians and Surgeons of this city was defeated by 30 votes to 5.

A faulty wording of the clause providing for the introduction of the four-year course, however, has led to unexpected delay in the general adoption of the measure. The clause reads : "Candidates for the degree of Doctor of Medicine in 1899 and thereafter" (who) "shall have pursued the study of medicine for four years," etc. Construed literally this evidently does not forbid matriculates of the present session graduating in 1898. It did not take long to discover this flaw and although at this meeting it was generally understood and repeatedly asserted that the four-year course was to become compulsory this fall, many schools took advantage of it. Many, however, had announced the adoption of the fourth year before this interpretation had been published. Among these was the University of Maryland, the College of Physicians and Surgeons of Baltimore and our own college ; and although the Judicial Council of the American Medical College Association on October 19 announced that the colleges were at liberty to graduate matriculates of this year in 1898, I am proud to be able to declare that this action has not altered the determination of these schools.

Much yet remains to be done to perfect and render uniform the curriculum, especially by lengthening the term to eight months and rendering the preliminary examination more effective. Who supposes, for instance, that the latter will amount to anything more than a mere formality, if indeed that, as long as it is in the hands of the faculties themselves? We were, therefore, pleased at the amendment proposed by Dr. Beverly Cole of California, requiring the

preliminary examination to be conducted by a board "in no wise connected with a teaching body of a medical college." The best disposition of this examination would be to place it, like the examination for license, in the hands of the State examining boards.

Yet, in spite of incompleteness, it must be with astonishment that we look back upon the vastness and suddenness of the changes. For fifty years the need of reform in medical education has constituted the staple of medical editorials, of public addresses and of the national gatherings. The American Medical Association passed resolutions again and again and used its great influence in vain. The colleges attempted themselves to achieve a reform, but selfishness and want of harmony brought their efforts to a quick and inglorious end. It would seem, therefore, that the time must have been ripe for action and as in the case of individuals, when the colleges had once made up their minds for a change, they went further and faster than they intended. It is true that they have been spurred on and backed up by recent medical legislation and by the action of efficient boards of health and examining boards ; but this should not detract from the merit of their own achievement. They have shown, in fact, that they could rise to the demands of the hour; they have realized the duty and responsibility imposed upon them ; they have lightened the labors of the boards and have hastened the rising of the tide. The American Medical College Association is now a power in the land and its beneficent influence will be seen for many years to come.

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HEALTHY BEEF.—Two Germans at Hamburg have made an extensive examination of over 8000 imported beeves and found only four of them, or 0.05 per cent., diseased while 8 per cent. of the German beeves slaughtered were unfit for consumption. This should help to remove the unjust suspicion that all American beef is unhealthy and the United States should demand an honest meat inspection at the foreign port of entry.

## THE TREATMENT OF CERTAIN PUS TUBES BY DRAINAGE THROUGH THE VAGINA.

READ BEFORE THE CLINICAL SOCIETY OF MARYLAND, DECEMBER 6, 1895.

By *J. Mason Hundley, M. D.*,

Associate Professor of Diseases of Women and Children, University of Maryland.

THE following is a report of four cases recently treated by me at the Maryland University Hospital. As will be seen, they were cases of a very serious nature and I think the results attained fully justified the procedure of attacking the pus collection through the vagina rather than by celiotomy.

CASE 1. Mrs. McI., aged 24. One child, six miscarriages, last one occurring eight months ago. She bled from the time of the miscarriage in March until the 16th of May, when she was curretted. About the middle of the following month she had a hemorrhage, after which time she improved and felt perfectly well until about the 1st of October. She noticed about that time a slight yellowish discharge from the vulva. She is separated from her husband and my impression is that she thought she had contracted gonorrhea. The doctor she consulted, she said, dilated her womb and put in a piece of cotton saturated with iodine, which was allowed to remain twenty-four hours. The vagina was also tamponed. This line of treatment was gone through with five times, when she became so ill with pain in the lower abdomen and left ovarian region, fever and vomiting, that she decided to consult another doctor. Dr. Funck was then called and later asked me to see her in consultation. When I saw her she had a pulse of 120, temperature 102°, looked septic, had enormous abdominal distension, tenderness on pressure and required opiates to relieve her of pain. Upon making a vaginal examination I diagnosed a pyosalpinx. She entered the hospital December 2 for operation and on the evening of the third I was telephoned for by Dr. Funck, who thought that the pus tube had ruptured into the general peritoneal cavity, from the character of the

pulse, pinched expression of the face, etc. On reaching the hospital I found her condition very much improved and decided that the tube had not ruptured. On December 4 this woman was operated upon. I punctured the pus collection through the posterior fornix of the vagina and about two ounces of pus were evacuated. Upon introducing the finger I found that this came from the left tube only. The pus cavity was drained and the next morning her temperature was normal, pulse 75, and remained so.

December 21. Since the report of this case the woman has not at any time had a temperature above normal and she is symptomatically well.

CASE 2. Mattie J., aged 19, colored. Married four years. No children; no miscarriages. Was well up to July 4, 1895, on which day she was taken with severe crampy pains over the entire hypogastric region. She vomited occasionally, had some fever and night sweats from July 4 until admission in the hospital October 29. She had menstruated regularly up to September, but she missed September and October. About the middle of August noticed an enlargement of her belly. When I saw her in the ward her face was puffy, she was greatly emaciated, temperature fluctuating between 99° and 102°, pulse 90 to 120, abdomen tympanitic anteriorly, dull in the flanks, which dulness disappeared upon change of position—evidently fluid—dulness over the entire lower abdomen and a cystic tumor could be made out reaching higher up on the left than on the right side. Vaginal examination revealed the true pelvis filled with a firm, unyielding mass.

The diagnosis was pus tubes probably complicated by a fibroid, though the girl was very young to have such a large fibroid. It was quite certain that the

mass was of inflammatory origin. She was operated on November 1. The abdomen was first opened to find out the true condition. The amount of fluid in the abdominal cavity complicated somewhat the diagnosis. Much bloody peritonitic fluid was evacuated and the intestines and omentum were found to be adherent in every direction and to bleed on the slightest touch. Her condition was so bad, having been so long septic, that I concluded it would be best to evacuate the pus tube through the vagina. The opening was made in the posterior fornix and about a pint of pus escaped. The abdominal incision was closed and the vaginal wound was kept open by a rubber drainage tube. She went along without any trouble with a temperature never more than 100°. In three weeks she was out of bed and left the hospital December 13, in good condition. The abdominal wound was healed, but there was still some discharge of pus from the vaginal opening. She is not well, but in a very much better condition than when she entered the hospital; it may be necessary to enucleate the tube through the abdomen later on. I am satisfied that had I attempted to enucleate the tube the woman would have died on the table. She was thoroughly septic and the adhesions were numerous and firm.

CASE 3. Mrs. J. M., married, aged 35, gave birth to a living child, June 27, 1895. She was out of bed in ten days, but felt quite weak. About the middle of September she was taken with malarial fever. She got better and was up for a few days, but had a relapse about the first of October. She had at this time sweats, chills, nausea and at times loose bowels. She did not suffer much pain but had to take opium to induce sleep. About the 20th of the month something broke and pus escaped from the vagina, after which she felt better. The discharge has continued ever since. Her case was thought to have been chronic malaria. On the first of December I was called by her attendant to see her in Harford County. I found the woman much emaciated, having lost fifty pounds, with a sallow complexion and was unable to take any food except what was very easily digested. Upon

vaginal examination I found in the posterior fornix just behind the cervix a pin-hole opening, from which pus escaped. The diagnosis was a ruptured pus tube through the vagina. When brought to the hospital this opening was enlarged and several ounces of pus evacuated and the abscess cavity was curetted. The cavity was packed with iodoform gauze, the uterus was curetted and a good deal of debris and fungosities removed.

December 21. The abscess cavity has healed, leaving only a sinuous tract of about one inch. She left the hospital today. The cavity, after removal of the gauze, was washed out every other day with hydrogen peroxide.

CASE 4. Mrs. K. M., white, aged 29, married, two children, three miscarriages; menstruated regularly up to July, but missed July. About August 1 she was taken with a flooding which lasted two hours. She thought it was a miscarriage and did not call a doctor. She continued to bleed at irregular intervals and sent for Dr. Davis, August 26. He thought that she had had an incomplete abortion and on August 29 called me in consultation. When I saw her she had a very offensive discharge from the vulva, the vaginal roof was firm and unyielding, the posterior fornix bulging within the vagina. The woman looked septic, was vomiting and suffering severe pain, temperature 100°, pulse 130 and greatly tympanitic. Diagnosis, pyosalpinx, the result of an abortion. On the following day she was operated upon. An opening was made in the posterior fornix into what was supposed to be a pus collection, but which proved to be a pelvic hematoma. There was beginning suppuration in this encysted blood collection; the cavity was washed out and a drainage tube inserted. The uterus was also curetted and a great deal of debris gotten away. The cavity was washed out daily for about thirteen days. She made a complete recovery, but had some temperature after the operation for about thirteen days. She was out on the street in twenty-one days after the operation. I am satisfied that this was a case of extra-uterine pregnancy, and not an abortion.

## SOME RECENT CASES IN ABDOMINAL SURGERY.

REPORTED TO THE CLINICAL SOCIETY OF MARYLAND, DECEMBER 6, 1895.

*By Thomas A. Ashby, M. D.,*

Professor of Diseases of Women, Baltimore Medical College.

CASE 1. This is a case of pus sac of each tube and ovary. I have known the patient for some time. The tumor was hard, closely attached to the surrounding parts, and I was inclined to think it was a fibroid. During the month of October she had some trouble in the family, which threw her into a nervous condition and which possibly led to the reformation of pus in the pelvis. Before that there had been simply a hard tumor. She lived out of the city. I visited her on a Monday and finding evident signs of pus in the pelvis told her to come to the hospital at once. She declined to do so and I left her, not knowing whether I should see her again or not. On Wednesday I was called again and the first statement made to me was, "Doctor, I have no pain in my abdomen and think I must be getting typhoid fever." Her temperature was  $104^{\circ}$ , pulse 110. I again insisted upon her coming to the hospital for operation. She accepted my advice this time and on the following day I removed the two sacs. The next day temperature fell to normal; has since reached  $100^{\circ}$  only once, and tomorrow she will be sent home.

CASE 2. I have here a small pus sac, which I desire to show because I consider it an exceedingly interesting one. It was removed two weeks ago from a girl nineteen years of age. She had had gonorrhea. I could feel a movable tumor in the pelvis, but was not satisfied that it contained pus. Her temperature alternated from normal to  $102^{\circ}$  from day to day, running down sometimes to  $98\frac{1}{2}^{\circ}$ , jumping in a few hours to  $102^{\circ}$ , where it would stay possibly twelve hours and then return to normal for three or four days. After she had kept this up for some time I decided to operate. I found pus in the ovary, the tube attached to the ovary and communicating

with the uterus. The pus was draining out into the cavity and a variable temperature was no doubt due to the filling and emptying of the tube. On the opposite side the tube was not involved and I left it alone. This case looked at one time like an intermittent fever and she was kept on quinine until I was satisfied of the presence of pus. There was no inflammation around the tube.

CASE 3. This specimen was removed from a patient of Dr. Bond's. It had existed for some time and felt more like a solid tumor. I found a large pus ovary on one side and the patient made a good recovery after its removal.

CASE 4. Here is a specimen in the fresh state which was removed from a colored woman who showed the signs of intrapelvic inflammation and a mucopurulent discharge from the uterus. The ovaries and tubes were destroyed and torn all to pieces by destructive inflammation. The uterus was very large, friable, evidently infected and its posterior surface adherent to neighboring organs. I removed it, cutting it off at the junction of the cervix with the body. She has a normal temperature today and no trouble whatever. The intestines were attached all around and gave considerable trouble during the operation.

CASE 5. This is a fibroid removed a few weeks ago. The tumor was irregular and nodular and a portion of it was lying in Douglas's cul-de-sac. It had given trouble simply from its mechanical pressure on the bladder and intestines. It was growing quite rapidly and I felt justified in removing it. She recovered without any trouble. In this same connection I want to show a specimen with three fibroids taken from one case. They were a large tumor hanging in the cavity, an intra-mural one and a subperitoneal. The patient recovered though she was very anemic

from the previous loss of a large quantity of blood. There are some points in connection with these operations to which I would like to refer. I do not believe from my observations that the uterine artery penetrates the walls of the uterus at all. If you simply clamp the ovarian arteries on either side you may remove the uterus and have no hemorrhage from the uterine arteries. It is claimed that the vessel anastomoses with the ovarian and does not of itself supply the walls of the uterus except to a limited extent.

CASE 6. This is a papilloma of the ovaries removed from a woman of fifty-five. I do not think I have ever seen anyone so distended by ascites. Three and a half gallons of fluid were measured and she lost probably one and a half gallons more. She was anemic and had general anasarca. She was unable to lie down, and sat in a semi-recumbent posture while I operated. The tumor was encysted and shut off from the general abdominal cavity. I did not remove the sac, which had no communication with the abdominal cavity, but cleaned out its contents and packed the wound with gauze. She returned home in five weeks and when I heard from her three weeks ago she was living in good health. There was some weakening of the abdominal wall and she was compelled to wear an abdominal support.

CASE 7. This case had been diagnosed as an extra-uterine pregnancy and there was everything to lead to that diagnosis. Primary rupture had occurred while under another physician's care. When secondary rupture occurred she was brought to town. I agreed with the doctor in his diagnosis, and when I operated I removed this mass. She recovered after some weeks of illness.

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### Society Reports.

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#### CLINICAL SOCIETY OF MARYLAND.

MEETING HELD DECEMBER 6, 1895.

THE 314th regular meeting of the Clinical Society of Maryland was called to order by the President, Dr. J. M. Hundley.

The following named gentlemen were elected to membership: Drs. W. L. Pressy, J. M. H. Rowland, R. C. Reuling and T. R. Greenly.

Dr. T. A. Ashby reported SOME RECENT CASES IN ABDOMINAL SURGERY (See page 224), and exhibited specimens.

Dr. J. W. Williams: This tumor (the last one), is a parovarian cyst. On the superior part of the tumor you will notice the perfectly intact tube and the tumor is soft and flaccid. The peritoneal covering of the tube extends over the side walls of the tumor and ovary. In the latter the corpus luteum is well made out. The diagnostic difference from other tumors from an anatomical standpoint is just this, in these cases the broad ligament is pushed apart and the tumor and tube are covered by the same peritoneum.

Dr. Ashby reported one case showing several forms of myomata of the uterus. A year or so ago I looked up the literature of that subject and was impressed by the fact that the vast majority of these cases had been diagnosed as uterine polypi. They had a tumor hanging from the uterus. The tumor was removed and the patient came back later with hemorrhage which was found to come from the stump of the polypus. After death sarcoma of the uterus would be found. The primary tumor then must have been sarcomatous. I bring this forward to show that such tumors are not always benign. I do not wish to be understood as saying that all uterine polypi are sarcomatous, but that many are and remembering that they are not always benign we should have each tumor carefully examined.

As to the arterial supply of the uterus, I agree with Dr. Ashby to a certain extent. As I understood him he thinks that the uterine artery plays no important part in the nutrition of the uterus. My work shows me that the blood supply is something like this. The ovarian arteries supply the ovaries and tubes and run down on the uterine walls. The uterine artery goes across the base of the broad ligament and reaching the uterus about the region of the internal os bends upwards to anastomose

with the ovarian. The uterine does play an important part in the nutrition of the uterus by sending branches into the uterine substance. The main vessel does not penetrate the uterine wall, but its small branches do. When we operate we may separate the main trunk from the uterus and the bleeding of the small branches will be controlled by the tearing through of their walls. Prat was the first to demonstrate that the organ might be removed without ligating the uterine artery.

In considering the papillomatous condition of the ovary we distinguish two classes, the papillomatous cysts and the superficial. In the first we have a cyst in which the stroma plays an important part. It is always enclosed within a sac and is the ordinary form of papilloma of the ovary. In the other form, instead of a cystic formation, we find in the center of the tumor an ovary, and along its surfaces this arborescent growth and if you cut a cross section you will find a good ovary in the sac. It gives rise to more ascites than the cystic form. This was considered up to the time of my article on the subject the rarest form of ovarian tumor known. Frommel stated that up to that time he had been able to find only eight cases of superficial papilloma of the ovary recorded. I came across five cases myself in a short time, and after carefully going over the literature found enough to bring the number up to twenty-three. At the present time there are not less than fifty on record. It is not, therefore, as rare as was formerly supposed. They were simply overlooked. These tumors are not malignant in the true sense of that word, but they are clinically malignant because of the large amount of fluid which transudes through them and the rapid loss of strength on the part of the patient.

*Dr. J. D. Blake:* I would like to ask Dr. Williams if sarcomatous tissue has ever been found in these uterine polypi?

*Dr. A. K. Bond:* Has Dr. Ashby had any experience with pus tubes due to the vulvo-vaginal catarrh of children extending through the uterus to the tubes? I am inclined to think that

these cases sometimes leave the child crippled for life, and that we should pay more attention to vulvo-vaginal catarrh than we do. I should like also to know his views in regard to the taking out of a healthy ovary in case there has been a pus sac on the other side. Some urge that both should be removed. In the case mentioned I opposed this advice given by two gynecologists. The patient has gone on for over a year now in comparative comfort, but I should like to know whether I was right or not.

*Dr. Randolph Winslow:* In regard to the cases of vulvo-vaginal catarrh I should say that they are gonorrhreal in the vast majority of cases. I have seen a case in a child of three years with no history of the infection and with no means of contamination. The gonococci, however, were present in the discharge. In regard to the papillomatous tumor I have very recently removed one. I do not know how long it had been in existence, but all the symptoms were getting worse and I operated. Peritonitis was present and she had an enormous ascites. The tumor ruptured during the operation and sago-like masses were discharged over the peritoneum and could not be removed thoroughly on account of her condition. She was very weak and we feared that she would die on the table. The trouble in the abdomen has returned and is doubtless due to these masses which were unavoidably left.

*Dr. R. M. Hall:* I want to ask Dr. Ashby whether there is a pelvic cellulitis independent of pyosalpinx, and if there is, what are the points of differential diagnosis?

*Dr. J. W. Williams:* In answer to Dr. Blake I would say that there is no doubt that some of these polypi are sarcomatous. I have seen them examined. The sarcoma is ordinarily stated to be a new growth of connective tissue. When in Prague two years ago I found a case in which I was able to prove that you can have a sarcoma-like tumor arising from the muscle cells. So these tumors can arise both from the connective tissue and the muscle, the latter being, however, very rare. About the vulvo-vagi-

nitis, I wrote an article a few years ago on that subject and stated that in the majority of cases I could demonstrate the gonococci in the pus. Epidemics have been reported in boarding schools and in one case the infection was traced to the bath tub. The school was well managed. There was no chance of their playing with one another's genitals and they must have been infected by the water. Sanger has said that a considerable number of cases of pyosalpinx were due to extension upwards of vulvo-vaginitis.

*Dr. T. A. Ashby:* In regard to the circulation of the uterus I did not intend to convey the impression given. I meant to say that by dissecting away the peritoneum you could cut off the uterus without any serious hemorrhage. Dissect away the peritoneum at the lower portion of the uterus and you will not have to ligate the uterine artery if you keep close to the walls of the uterus. I have never seen a case of pus tube in a girl under 19. The case reported tonight is the youngest. She was treated for gonorrhea and the result was as stated. The right was not involved at all and was not disturbed. I do not think we should in these cases remove a perfectly healthy tube. In Dr. Bond's case I did believe that the other ovary should be condemned. She was near the time of life when the ovary was of no value. She had infection of one side and I thought it best to remove both ovaries and prevent possible trouble of the other. I do not think that we should as a rule remove healthy ovaries even when we have a pus sac at one side unless there are very good reasons for doing so.

*Dr. J. M. Hundley* read a paper on THE TREATMENT OF CERTAIN PUS TUBES BY DRAINAGE THROUGH THE VAGINA. (See page 222.)

*Dr. J. H. Branham* reported two cases similar to the ones quoted above.

*Dr. T. A. Ashby:* I agree with these gentlemen in many respects. A great many of these cases can be relieved by puncturing through the vagina. It is not a radical operation and we are apt to have a return of the trouble, but the

patient may be placed in a better condition by the time gained by the simpler operation. I know from the specimens I have here and from results I have obtained that enormous pus sacs can be removed through the vagina. This sac, for instance, at the time of removal contained a gallon of pure pus. Five weeks from the date of her confinement she was seized with fever and treated for typhoid for three months. Not improving, she consulted another physician and the tumor was diagnosed. When I saw her she was in a very bad condition. I did a radical operation, drew off the pus, pulled out the tumor and removed it. She was not infected at all and the temperature which had been running up to 103° or 104° fell on the next day to normal and remained there. Her recovery was immediate and complete. In many cases it is difficult to remove these sacs and the best route to get the pus out is the best one to take. If you can drain through the vagina, all right, but if not you should go through the abdomen. Every case must be a law unto itself. I think Drs. Hundley and Branham are correct in the method employed for these cases, but where the conditions are favorable for a radical operation you should attempt to do it.

*Dr. J. W. Williams:* I think the ideas advanced as to the rather indiscriminate vaginal operations in these cases would be a decided step backward and if we agitate such views they will surely redound to harm. We are only justified in puncturing through the vagina when we have made an absolute diagnosis. Having decided on an operation it is best to open the abdominal cavity, for this is the only way to get at the exact condition of affairs. The most rational proceeding is to open the cavity and if we can remove the pus sac *in toto* it is surely best to do so. If, after a careful exploration, we find that we cannot remove the sac, then comes the time for puncturing. With the hand in the peritoneal cavity the sac can be punctured from below without any danger to the woman, and this is a better method than operating in the dark, and often necessarily without a

clear idea of what we are doing. Except in very rare cases, I would not feel justified in opening up from the vagina.

Dr. Hundley's first case is open to criticism. The woman was thought to have a rupture of the pus sac, with a temperature of 103°. The next day he punctured the sac through the vagina. I think he assumed a considerable risk and though the result proved successful I do not think the woman had the best chance offered her. I am reminded of a case seen last June. The woman was examined under an anesthetic and a pus sac of one side diagnosed. The tube and ovary of the opposite side were normal. That afternoon her temperature began to go up, and at 4.30 had reached 104°, pulse 120 and other symptoms of acute peritonitis. She was placed on the table and laparotomy performed. The peritoneal cavity contained bloody pus. The fimbriated extremity of the tube had become separated during the examination in the morning and pus was poured out into the cavity. She was thoroughly washed out. The temperature fell at once and remained at normal. I think Dr. Hundley's case should have been operated upon in the same way. His result was good, but I do not think the operation was the proper one.

*Dr. J. D. Blake:* If I understood Dr. Hundley rightly he called attention to the fact that his treatment was especially concerned in those cases where there was a large collection of pus, easily made out as projecting into the vagina, and the condition of the patient such as he did not think would warrant any prolonged operation. I would like to take exception, however, to one of the cases reported by Dr. Hundley. At the same time that he drained the pus sac into the vagina he curetted the uterus without giving us to understand that there was hemorrhage from that organ. Having a profuse discharge of pus draining into the vagina would it be well to curette the uterus? The instrument might be very easily infected and carrying the organisms into the uterus give rise to trouble on the other side.

*Dr. J. M. Hundley:* I meant to make it clear that where an operation could

be done on such cases as Dr. Ashby has shown that no one would attempt to puncture through the vagina and that the cases I have related were bad cases of large collections of pus. I do not say that they should be punctured if the conditions are proper for enucleation. You should enucleate the whole thing, but in my cases it would have been almost impossible. About curetting the uterus, infection can be carried to the pelvic cavity in that way, but I expect this woman was already infected, for that was the way the disease came about.

H. O. REIK, M. D.,  
Secretary.

### Correspondence.

#### THE MEDICAL LIBRARY.

Editor MARYLAND MEDICAL JOURNAL:

*Dear Sir:* — Having been for some years a member of the Library Committee of the Medical and Chirurgical Faculty, I have come to see very clearly the strong and weak points of the library. It goes without saying that at this age of the world a medical library is an absolute necessity. A profession that does not read is a profession that is standing still. Our library is satisfactory in two departments: first, we have an excellent collection of medical classics. In writing a paper, or in reading up some special subject, it is always interesting and often profitable to review the historical literature, and while we have by no means a complete collection of the older writers, still we have most of the older books, and many rare and valuable volumes.

In the second place we have an excellent journal library. Beginning ten or fifteen years back we have all the important journals, general and special, of this country, England, Scotland, Ireland, France, Germany, Italy, Belgium, Sweden and Norway, etc. The sets are reasonably complete, and in some instances, as for example the London *Lancet*, we have complete sets of journals from the beginning. The weak point in the library is in new books. The com-

mittee can with difficulty keep up the journal list, and in fact have from time to time to reduce the number because of insufficient funds. This being, unfortunately, the case, it is impossible to buy new books.

The plan I would propose is as follows: Let each of the various societies agree to place upon the shelves a certain number of volumes each year, allowing of course their members to have access to them. For example, the Clinical Society could buy works upon clinical medicine, the Medical and Surgical Society on surgery, the Obstetrical and Neurological Societies books in their specialties, etc. In this manner the great deficiency in the library could be made up. In the new home of the Faculty there is ample room for three or four times the volumes we have at present. The rooms are well lighted and heated and in a short time it is hoped to have the books well arranged. The expenditure of a little money in this way would be of inestimable value to the profession at large. We are no longer permitted to get books from the Surgeon-General's Library, as was formerly the case, and it seems to me that it is absolutely necessary for us to do something if we are to keep up with what is going on in medical literature. The Faculty is now, and will be for some years, unable to do more than keep up the new building, and therefore I venture to make this appeal, hoping that some members of the various societies will take up this important subject and present it as forcibly as possible to their fellow members.

Yours truly,  
GEORGE J. PRESTON, M. D.

#### A CORRECTION.

Editor MARYLAND MEDICAL JOURNAL:

Dear Sir:—At the beginning of your report of my remarks on Dr. Lippincott's paper (MARYLAND MEDICAL JOURNAL, December 28, 1895, page 190), I notice a sentence where there occurs a misprint. The sentence as it is printed reads thus: "I refer first to the return

of the hyperemia." The sentence should read: "I refer first to the nature of the hyperemia." Taken in connection with what follows, the sentence as printed means nothing. Will you kindly make the correction?

Very truly yours,  
R. L. RANDOLPH, M. D.

#### Medical Progress.

ELECTROLYSIS IN STRICTURES.—Dr. J. A. Fort describes, in the *New York Medical Journal*, his method of treating strictures by electrolysis. He says: My electrolyser has all the advantages of the urethrotome and none of its inconveniences. It looks like a small whip of which the handle contains a metallic wire projecting from the end which connects with the flexible part. This instrument, being first introduced into the urethra, is connected with the negative pole of a continuous current battery, and the positive pole is connected near the affected part, on the front of the thigh or over the pubes; then the current is turned on.

The operation, which is almost painless, requires thirty seconds (on an average), with a current of a strength of at least ten millampères, as indicated by means of a galvanometer. The electrolyser remains perfectly cool during the operation. In nearly all cases there is no bleeding, or but very little. The urethra is made aseptic before and after the operation, in order to prevent fever. I never allow a sound to remain permanently in the urethra for any length of time after the operation.

\* \*

FOREIGN BODIES IN THE UTERUS.—Albertin (*British Medical Journal*) collects 24 cases. Two are original. In one case a laminaria tent remained nearly eleven months in the uterine cavity, and in the second a carbon rheophore was left behind, and did not come away for a week. In neither instance was there any symptom of irritation, and both the tent and the rheophore were expelled spontaneously.

MARYLAND  
**Medical Journal.**

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BALTIMORE, JANUARY 11, 1896.

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FAILING to find a cure for tuberculosis, attention has been directed by the profession, and to some extent by the public, to restrict the *Indiscriminate Expectoration*. Ease by cutting off as far as possible all means of communicating it in its pulmonary form from the sick to the well, or to those predisposed.

Dr. William G. Bissell of the Buffalo Department of Health has made some suggestions in the *New York Medical Journal* towards restricting the spread of tuberculosis, by preventing indiscriminate expectoration. To the average American who believes in freedom in the widest sense of the term the restriction of his innate right to "spit" may seem a hardship, but little by little the public is becoming convinced that the spread of the tubercle bacillus by careless and often unnecessary expectoration in public places is one important factor in helping to disseminate consumption.

The most common way of spreading pul-

monary consumption is by means of dried sputum. This is denied by few. The street car companies in many cities, and among them Buffalo and Baltimore, have been prevailed upon to place notices, to the effect that "spitting on the floor of the car is positively prohibited." This is a rule, but without the proper legislation to back it, it can be broken with impunity. During the year 1894, over forty million passengers were carried by the Buffalo street railways, and during 1895 in Baltimore about a million persons a week used the cars. It is easy to conceive of a convalescent riding in the cars, especially in cold, wet weather, when the doors and windows are kept closed, and thus exposing himself to a possible contagion from dried sputum containing tubercle bacilli.

Dr. Bissell has examined the dust from the cars of Buffalo, and the same might be done in the cars of any other large city, and he has succeeded in demonstrating tubercle bacilli in many cases. His conclusions are that much good can be done, and disease prevented by educating the public in general as to the danger of indiscriminate and careless expectoration, and by the passing of a city ordinance, prohibiting the expectoration on the floors of cars, in public buildings and similar places. Without these two preliminaries, nothing much can be done to prevent the disease. The health commissioner of that city sent to each physician a circular letter requesting a report of cases of pulmonary consumption to be sent to the health office, and in case of doubt to submit a specimen of the sputum of the suspected patient to the bacteriologist of the department, who without cost to the physician or patient will report the result of the examination to the physician and a circular of instruction prepared by the health department is sent to the family in which cases of tuberculosis occur.

Effective legislation is what is apparently needed in Buffalo and what is needed in many other places and it was with just such ideas as these that the MARYLAND MEDICAL JOURNAL has sent out a series of questions to about nine hundred physicians in Baltimore with the idea of obtaining some legislation which shall not be galling to the sick and shall at the same time have some consideration for the well or the delicate ones predisposed to this terrible scourge. The answers to these questions have not come in as one

would have the right to expect. Through apathy, indifference, carelessness, forgetfulness, attention to personal interests only, many of the physicians whose opinions are desired have failed to notice the questions, although the answering of them demands little trouble and less time.

It is proposed to seek legislation from the State, and meanwhile it is again asked that every physician, whether he be in favor or opposed to any move which will tend to restrict tuberculosis in any form, to reply to these questions sent out and put the State of Maryland and the city of Baltimore on an equal footing with other progressive States and cities which are doing philanthropic work in preventive medicine.

\* \* \*

AS A matter of historical record, it is interesting to note in the article by Dr. Eugene F. Cordell on the American Medical Education. Medical College Association, with what difficulties

he had to contend in his original plan to raise medical education, and too great credit cannot be given him for the successful results of his work. As in the case of so many reforms, no one took especial interest in it, because no immediate practical good could be seen by those too nearsighted to see a great distance, but no sooner did a few of the more powerful colleges take a stand than all the rest followed like good sheep and the College Association became a reality, and that it has been of inestimable advantage to medical schools, to the students, and especially to the public, all who have any acquaintance with medical education in this country are too well aware.

A loose wording of the law regarding the classes beginning last fall gave some schools the opportunity to anticipate a graduating class in 1898, and this the schools technically had a perfect right to do, although the spirit of the law evidently intended a four-year course to begin with the fall of 1895. The mere fact, however, of announcing a four-year course in a catalogue has hardly yet given the students an advantage over the three-year course, and in too many schools it has amounted to spreading exactly the same curriculum over a longer period with no gain to the student.

The development of an advanced course in medicine must be gradual, and hence it may

take several years before all departments are working up to the requirements. A longer course may mean greater expense to the student, but it certainly costs the schools more and those with limited incomes cannot make all the changes in one year. It is probable that in the next few years the best schools will have a bona fide four-year course, which shall give the student just what he is paying for and will not be a loss to the school itself.

\* \* \*

IT IS WITH great pleasure the trustees announce that tonight the rooms of the Medical and Chirurgical Fac-

*The Medical Library.* ulty on Hamilton Terrace will be opened formally by addresses on subjects pertaining to the medical libraries and the medical association. Dr. Chadwick of Boston, who has a thorough knowledge of the needs of a medical library, will be present and deliver an address on some subject relating to librariés, and it is hoped that Dr. John S. Billings, who has been invited, will also make a few remarks. Officers of the Faculty will also have a few words to say and the affair will end with a social reunion and a collation. The suggestion made by Dr. Preston in this issue is one well worthy of consideration. The library needs new books. Many of the local societies have few expenses and have accumulated a surplus which could in part be well used in buying a few books which could always be used by members of that society whether they were members of the Faculty or not. The trustees of the library and all the officers are in earnest in desiring to give to the members a fine building and better facilities, and all should make it a point to be present and see for themselves the great changes and advantages of the new building which will be formally opened.

\* \* \*

WITHOUT the intention of reflecting on any one member of the State Board of Health, it must be admitted by all

*State Board of Health.* those who ever notice the records of the work of this body, that they compare very unfavorably with work done by similar boards in many other States. There is not only needed a complete re-organization of the present board of health, but the laws governing this body need thorough revision to bring them up to the present time.

## Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending January 4, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		27
Phthisis Pulmonalis.....		27
Measles.....	65	5
Whooping Cough.....	15	1
Pseudo-membranous Croup and Diphtheria.	19	8
Mumps.....	2	
Scarlet fever.....	14	
Varioloid.....		
Varicella.....	2	
Typhoid fever.....	2	2

Sir Joseph Lister has been elected President of the Royal Society.

It is a source of congratulation to the readers of the *Medical News* that the new editor is not a spelling reformer.

*Langsdale's Lancet* is a new monthly published at Kansas City, Missouri. Dr. John M. Langsdale is the owner and proprietor.

The Health Department of Baltimore has found a large amount of the sulphide of arsenic and sulphuric acid in a barrel of pickles.

Dr. George H. Rohé, superintendent of the Maryland Hospital for the Insane, makes a very encouraging report of the work of that institution, showing an unusual number of cures from curable insanity.

There will be held at Washington, D. C., on February 10, 1896, a competitive examination of candidates for appointment to the position of Assistant Surgeon in the United States Marine Hospital Service.

Courses of lectures for special students have begun at the Johns Hopkins Hospital and will continue through March. Baltimore physicians may attend these lectures without charge by registering at the medical school.

The Nurses' General Directory at the new hall of the Medical and Chirurgical Faculty, 847 North Eutaw Street (Hamilton Terrace), open from 10 A. M. to 6 P. M., has available hospital-trained nurses, graduate and non-

graduate, male and female, white and colored, for all purposes.

The *Western Reserve Medical Journal* has ceased to exist and has been succeeded by the *Cleveland Journal of Medicine*, which is the official journal of the Cleveland Medical Society. Drs. Henry S. Upson and P. M. Foshey are the editors and proprietors.

Dr. Abraham S. Schloss, a former resident of this city, but for the past ten years a practicing physician in New York, died on Tuesday, aged forty years. He was born in Martinsburg, W. Va., and was a graduate of the Maryland University in 1884. A wife and two children survive him.

The *Medical News* is authority for the statement that a large retail shop in Baltimore sells tickets at 29 cents, each ticket entitling the holder to free medical service of "one of Baltimore's prominent doctors, a graduate of the Maryland University, who has practiced among you for 11 years," etc. "He will accept our tickets for a visit any time you see fit to call him, day or night. We shall sell these tickets for 29 cents each. When the doctor calls, all you have to pay is the ticket you bought of us for 29 cents. These tickets are good for one year, and you can get as many as you wish today for 29 cents, and the doctor will accept one ticket for each visit. It makes no matter what we pay the doctor; you only pay 29 cents for a visit."

The library and new hall of the Medical and Chirurgical Faculty of Maryland, at 847 North Eutaw Street (Hamilton Terrace), and 864 Linden Avenue will be formally opened tonight. Dr. Charles G. Hill, the president, will make the opening remarks; the address of welcome will be delivered by Dr. L. McLane Tiffany, President of the Board of Trustees; a financial statement will be made by Dr. Thomas A. Ashby, Treasurer of the Board of Trustees; Dr. James R. Chadwick of the Boston Medical Library Association will deliver an address on Medical Libraries; Drs. John S. Billings, George M. Sternberg, Fletcher and Huntington of the United States Army, will also make remarks. The addresses, which will not be long, will be followed by a collation. Invitations have been sent to all members of the Faculty. The reception committee consists of Drs. T. A. Ashby, Wilmer Brinton, G. Lane Taneyhill, Louis McLane Tiffany and William Osler.

## WASHINGTON NOTES.

The Washington Obstetrical and Gynecological Society held its regular meeting on Friday, January 3; the President, Dr. George Byrd Harrison, in the chair. Dr. H. B. Deale read an interesting paper entitled "Movable Kidney," which elicited an interesting discussion by Drs. Joseph Taber Johnson, Henry D. Fry, George B. Harrison, J. Wesley Bovée and H. L. E. Johnson. Dr. J. T. Kelley presented a specimen of a large fibroid of the uterus, complicating a two months' pregnancy. Dr. H. L. E. Johnson presented a specimen of a large ovarian cyst. Dr. J. T. Kelley read a paper entitled "Fibroid Tumors with Pregnancy." The discussion was to be opened by Dr. H. D. Fry, but on account of the lateness of the hour and the importance of the subject, the discussion was deferred until the next meeting of the Society.

The annual election of officers of the Medical Society of the District of Columbia was held on January 6. The following officers were elected: President, Dr. Samuel C. Busey; Vice-Presidents, Drs. J. H. Bryan and J. Wesley Bovée; Recording Secretary, Dr. S. S. Adams; Assistant Secretary, Dr. H. L. Hayes; Corresponding Secretary, Dr. Thomas C. Smith; Librarian, Dr. E. L. Morgan.

## Book Reviews.

**THE INTERNATIONAL ENCYCLOPEDIA OF SURGERY.** A Systematic Treatise on the Theory and Practice of Surgery, by Authors of Various Nations. Edited by John Ashhurst, Jr., M. D., LL. D., Barton Professor of Surgery and Professor of Clinical Surgery in the University of Pennsylvania; Surgeon to the Pennsylvania Hospital, etc. Illustrated with chromo-lithographs and wood-cuts. In seven volumes. Volume VII. Supplementary volume. New York: Wm. Wood & Company, 1895.

The editor in the preface says, "The object of this supplementary volume is to furnish to the readers of the International Encyclopedia of Surgery a brief but sufficient account of such additions to both surgical science and surgical art as have been brought forward during the seven years which have elapsed since the revised edition of the original book was published, and as have seemed

of sufficient importance to justify their incorporation in a work of this character, which makes no claim to be an ephemeris of theoretic novelties, but rather to be a trustworthy digest of accepted and established facts." In the accomplishment of the object as expressed above Dr. Ashhurst has associated with himself 47 other authors, all of whom are Americans, and in this respect the present volume loses its international character. Some of the original articles are so exhaustive that little or no additions or corrections have been found necessary, whilst others require to be almost entirely rewritten. The whole field of cerebral surgery has been developed since the last revision of its work, and the present article by Professor W. W. Keen of Philadelphia is a careful exposition of the whole subject. The subject of tumors is also quite exhaustively considered by Dr. Curtis of New York, but most of the articles are comparatively short and only record the advances made in the last seven years. The article on excisions by Professor Ashhurst gives a tabulated statement of his personal experience in this line of surgery, in which the results are seen to be extremely good, both in regard to the small mortality and the usefulness of the limbs. As has been said, this volume is a supplement to the preceding six volumes of the original work, and to those who have the other volumes this one is absolutely essential. In illustration of this remark, I quote a paragraph from an article by Professor Nancrede, who says on page 562, "Under no circumstances should my former advice be taken to apply poultices after opening pus collections." But this book will be found very useful even to those who do not happen to possess the other volumes. I commend to everyone the articles on fracture of the patella by Dr. Packard and on urinary calculus by Dr. Keyes.

**THE PATHOLOGY AND SURGICAL TREATMENT OF TUMORS.** By N. Senn, M. D., Ph. D., LL. D., Professor of Practice of Surgery and Clinical Surgery, Rush Medical College; Professor of Surgery, Chicago Polyclinic; Attending Surgeon to Presbyterian Hospital; Surgeon in Chief, St. Joseph's Hospital, Chicago. Illustrated by 515 Engravings, including full page colored plates. Philadelphia: W. B. Saunders. 1895.

Professor Senn is probably the most prolific medical writer on this continent, and his contributions to literature cover almost the whole

field of surgery. He is known for his careful and thorough work in whatever he undertakes, seeking to lay a firm and sure foundation upon which to build. The present treatise will only serve to confirm the opinion just expressed, as the opening chapters are concerned with the origin and nature of tumors, the morphology of tumor cells, the anatomy and biology, pathology and etiology of tumors, before proceeding to the most practical parts of the subject. Chapter IX is devoted to the diagnosis of tumors. In speaking of the microscope as an aid in the diagnosis of tumors, Dr. Senn says: "There is no doubt in the mind of the writer that the value of the microscope as an aid in the diagnosis has been greatly overestimated," and he cites the case of the late Emperor Frederick as an example of mistaken diagnosis from a microscopical standpoint, nevertheless he considers "the microscope to be an invaluable aid in the diagnosis of tumors," and he recommends the use of the freezing microtome at the time of the operation.

The treatment of tumors is divided into 1. Medical; 2. Surgical; 3. Palliative. Dr. Senn says: "It is the recognition of the nature, location and clinical tendencies of tumors that distinguishes the honest and competent surgeon from the charlatan. The cancer-quack calls every swelling a tumor." "No kind of internal medication has any influence whatever in limiting tumor growth, much less in causing the disappearance of a tumor," if we exclude infective swellings, and the only rational treatment of most true tumors is by means of surgical operations. The treatment of tumors by the injection of cultures of the streptococcus of erysipelas is not recommended by the author. In regard to the treatment of carcinoma the author gives expression to views which appear to the reviewer to be fraught with wisdom, when he says "The writer is an ardent advocate of all legitimate attempts to eradicate carcinoma by operation, but is satisfied that the *furore operativus* have been carried too far at the present time. The surgeon has no moral right to become a legitimate executioner under any circumstances." All the various forms of tumors are carefully described, and illustrated, and it is safe to say that the volume is thoroughly abreast with the most recent views in regard to this important class of ailments.

## Current Editorial Comment.

### DIET AND MEDICATION.

*Medical World.*

EVERY young man or woman, desiring to enter the profession of medicine, should not only have a liberal classical education, but should also be a skillful cook. Then they should take at least a thorough course in a medical college of unquestioned standing, after which they would be ready to begin to understand how to properly and successfully practice the healing art.

### COKKI OR COCSI.

*Cleveland Journal of Medicine.*

OF medical terms probably none is more persistently mispronounced than *micrococcii*. The hard sound of the second "c" is warranted by neither authority nor analogy. The *Century Dictionary*, the best American authority, as well as one of the most liberal in matters of pronunciation, gives *si* as the sole pronunciation of the last syllable, and Gould and Foster do not give their opinion at all. One of the few rules of pronunciation fairly well adhered to in the English language, as well in words of Greek origin as in others, is that giving the soft sound to "c" before "e" and "i". *Coccyx*, *bacillus*, *vaccinate* and many other words show this sufficiently. If the hard sound is given, let us at least spell the word with a "k."

### COMPULSORY VACCINATION.

*Medical Record.*

THE verdict for damages recently given in Brooklyn against a medical officer of the Health Department of that city, for the compulsory vaccination of a protesting citizen, carries with it a wide-spread significance as bearing upon the surrender of the personal rights of a citizen to the greater interests of the community at large. It is very unfortunate that the oft-asked question concerning the personal rights of individuals as bearing on the regulations of health departments should be so pointedly and directly answered as in the present instance. Under a claim of legal damages it establishes a precedent which may tend in many ways to hamper the action of health boards not only in their efforts to prevent the spread of disease on the one hand, but to arrest its progress on the other. This is to be regretted.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### A REVIEW OF THE NEWER SYNTHETIC REMEDIES; THEIR CHEMISTRY, PHARMACY AND THERAPY.

#### PART IV.

By *Oswald L. Schreiner, Ph. G.*,  
Madison, Wisconsin.

#### APOLYSIN.

**APOLYSIN** is chemically closely related to phenacetine and lactophenin. All three are derivatives of paracetamol.



By replacing one hydrogen atom in the amido group ( $\text{NH}_2$ ) by the radical of acetic acid ( $\text{C}_2\text{H}_3\text{O}$ ) phenacetine will be produced; by substituting the radical of lactic acid ( $\text{C}_3\text{H}_5\text{O}_2$ ) lactophenin will result; and by using citric acid in place of either of these two the so-called apolysin is obtained. A comparison of the structural formulas of these bodies will best show their relationships and differences:

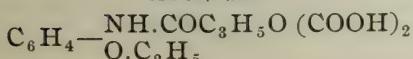
#### PHENACETINE.



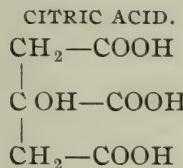
#### LACTOPHENIN.



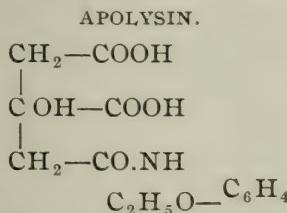
#### APOLYSIN.



Citric acid is a tribasic acid of the following constitution:



And since p-paracetamol is a monatomic base and these substances are caused to react one upon the other in molecular proportions, only one carboxyl group ( $\text{COOH}$ ) is affected. We may therefore also write the formula of apolysin thus:



Apolysin is a yellowish-white, crystalline powder, and as there are still two carboxyl groups (acid radicals) the compound possesses acid properties and a sour taste. It is soluble in 55 parts of cold water and in almost all quantities in hot water; freely soluble in alcohol and also in glycerine. Melting point 72° C. (161.6° F.).

Sulphuric acid dissolves apolysin without coloration, whilst its solution

in concentrated nitric acid, when warmed, becomes a bright orange color. One decigram ( $1\frac{1}{2}$  grains) of apolysin warmed with 1 c.c. (17 minims) of concentrated hydrochloric acid and afterwards diluted with ten times its volume of water turns ruby-red in color when a few crystals of chromic acid are added. This compound, like phenacetine, must be free from the highly poisonous mother substance p-phenetidin. (For method of detecting this see, under Phenacetine, MARYLAND MEDICAL JOURNAL, October 20, 1894.) Apolysin is more readily split up by diluted acid than is phenacetine; between these two, in this respect, stands lactophenin. With alkalies, however, just the reverse is the case, the phenacetine splitting up more readily than apolysin. This would seem to explain the fact that comparatively large doses of apolysin are entirely harmless when hypodermically injected, since it then comes at once into contact with the alkaline reacting tissues. Thus 8 cg. ( $1\frac{1}{4}$  grains) produced very little effect on white mice when injected subcutaneously, while only 3 cg. ( $\frac{2}{5}$  grain) of phenacetine sufficed to produce the poisonous action of phenetidin (Hildebrandt).

Apolysin, like the lactophenin already considered, is a comparatively recent production of chemical science; but, unlike the latter drug, it does appear to possess decided advantages over phenacetine and will no doubt push itself into the front ranks of the most valuable remedial agents of today. It was discovered in the scientific laboratory of the chemical factory of Dr. F. von Heyden's successors, in Radebeul, near Dresden, and was first introduced to the medical profession as an antipyretic and analgesic by Drs. Leon von Nencki and Joseph von Jaworski of Warsaw. These investigators subjected apolysin to a thorough therapeutical and clinical investigation. Experiments were made on frogs and rabbits which proved the non-poisonous character of apolysin.

Thus a 10 per cent. solution of apolysin containing 54 grains of the drug was injected into a rabbit weighing 47 ounces. The animal remained well, nor

did further investigation show anything abnormal in the animal's organism. They then took daily doses of 46 grains and by examining the urine were able to prove that the apolysin, in part at least, is eliminated from the system as the sulphates of p-amido-phenol and p-phenetidin. The latter they proved by the following process: The urine, voided one hour after the ingestion of the apolysin, was decomposed by an equal volume of hydrochloric acid and a 1 per cent. sodium nitrite solution and ammonia added until reaction became alkaline. The fluid became lemon-yellow, changing to rose-red upon again acidifying with hydrochloric acid. The urine did not reduce Fehling's solution, nor did it show optical activity in the polariscope; they therefore conclude that apolysin does not appear in the urine as glycuronic acid.

Experiments on animals in febrile condition were then undertaken. For this purpose two rabbits were employed; one of them was injected with diphtheritic toxin, the other with pure cultures of pyogenic streptococci. Both experiments turned out very satisfactorily.

In their clinical experiments they employed it both to test its antipyretic and analgesic effects, as well as its analgesic effects alone. The diseases in which they employed apolysin were as follows: Influenza, 13 cases; cephalgia of indefinite origin, 7 cases; follicular tonsillitis, 5 cases; croupous pneumonia, 4 cases; trigeminal neuralgia, 3 cases; puerperal fever, 2 cases; sciatica, 2 cases; lumbago, 2 cases; scarlatina, typhoid fever, pyemia, cervico-occipital neuralgia, facial erysipelas, each 1 case; and hemicrania, 3 cases; in all, 46 cases.

From the cases reported in detail, the following conclusions of the action of apolysin may be drawn:

Apolysin when administered to patients in febrile condition produces a fall in temperature and at the same time causes a decided diminution or entire disappearance of those distressing symptoms of pain that usually accompany these fevers.

Its action is quicker and surer than the other drugs of this series, due to its

greater solubility and consequent more rapid and complete absorption.

Apolysin is practically innocuous, and may therefore be given in large doses to attain a rapid and powerful analgesic and antipyretic effect. Observations show that it causes no unpleasant effects.

In neuralgia and other severe painful affections, apolysin lessens the pain, and often causes the symptoms to disappear entirely. It shortens the length of the individual attacks.

As apolysin is readily split up by acids it appears to be contraindicated on an empty stomach, or when there is secretory hyperacidity. This contraindication need not be heeded if instead of prescribing the acid apolysin in pure form it be given in combination with sodium bicarbonate. Apolysin tablets may now be had, composed of  $\frac{3}{4}$  grs. of sodium bicarbonate and  $7\frac{1}{2}$  grs. of apolysin. These dissolve in water with effervescence, the solution being slightly alkaline.

For adults the single dose is 8 to 30 grains; in divided doses it may be given up to 100 grs. daily. For children the daily dose is 2 to 20 grains, according to age.

The chief objection to phenacetine is its almost entire insolubility in water. Chemists have for some time been trying to form a compound which would possess the valuable proportion of phenacetine, but be soluble in water. Apolysin appears to fulfil these conditions.

The proportions of solubility of the three phenetidin derivatives are as follows:

One part of phenacetine requires for its solution 1400 parts of cold, and 80 parts of boiling, water.

One part of lactophenin requires for its solution 330 parts of cold, and 55 parts of boiling, water.

One part of apolysin requires for its solution 55 parts of cold, and less than 1 part of boiling, water.

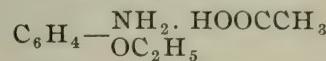
#### CITROPHEN.

#### CITRATE OF P-PHENETIDIN.

Citrophen bears to apolysin the same relation that the lactate of p-phenetidin

bears to lactophen, or the acetate of p-phenetidin to phenacetine.

#### P-PHENETIDIN ACETATE.



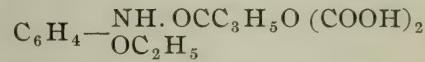
#### PHENACETINE.



#### P-PHENETIDIN CITRATE (CITROPHEN).



#### APOLYSIN.



In other words citrophen is simply a salt of phenetidin, while apolysin is phenetidin permanently combined with the citric acid in an anilid-like form. The addition of an alkali to citrophen causes the immediate separation of phenetidin as a free poisonous base; but the phenetidin cannot be separated from apolysin by this treatment. This difference in chemical constitution produces a decided difference in physiological action. That apolysin is non-poisonous is in accordance with the law discovered by Professor M. von Nencki (in the St. Petersburg Institute for Experimental Medicine), that the entrance of carboxyl radicals (acid groups) in a poisonous substance lessens or destroys its poisonous action. Citrophen on the other hand possesses the same proportion as does any other salt of phenetidin, the hydrochloride for instance, which is well known as a blood poison.

Treupel has investigated the action of citrophen on dogs and reports very unfavorably upon it. In the organism it is readily decomposed into p-amidophenol; the urine gives an intense indophenol reaction, and methemoglobin is found in the blood. Irritation of the digestive tract and of the nerves is noticed. Citrophen is therefore not to be recommended as a safe remedial agent.

## VAGINAL INCISION AND DRAINAGE.

READ BEFORE THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION,  
NOVEMBER 12, 1895.

By J. W. Long, M. D.,

Professor of Diseases of Women and Children in the Medical College of Virginia, Richmond.

IN presenting this paper to the Fellows of this Association I am aware that I bring nothing new to my hearers, but the procedure herein advocated is of such incalculable value, with clearly defined indications, that I wish to have you discuss it, and to send it forth on its life-saving mission. For surely if there is any operation which snatches a woman from the very jaws of death this one in many instances does.

*Indications.*—In those cases of pelvic inflammation in which there is an effusion of serum or collection of pus anywhere in the pelvic tissues outside of the tubes, the indication is to drain. If the serum or pus or blood is confined within the tubes, the only logical thing to do is to remove them. To drain tissues that can be safely and easily removed is folly and mere pretense.

In this connection it should be remembered that it is the sepsis outside of the fallopian tubes that causes systemic infection that kills. I desire to emphasize this. When the tubes become infected, nature sets to work to seal the fimbriated extremity and to coat over the entire tube with plastic lymph. If she succeeds in doing this before the infection passes through the tube and reaches the peritoneum, the patient is safe from all immediate danger. We are familiar with the trouble a "leaky pus tube" causes.

In proof of the assertion that septic matter confined within the tubes does not cause systemic infection, I show you the drawing from a specimen of double pus tubes complicating a fibroid uterus which I removed at the old Woman's Hospital recently. The right tube is distended with pus to the size of a forefinger. The left tube is adhered to the ovary so intimately that it is impossible to say where the tube stops and ovary

begins. They constitute a true tubo-ovarian abscess, containing a half pint of pus. The amount of pus and the nature of the fusion between tube and ovary shows that it must have existed months and probably years, yet there was no sepsis.

On the other hand a small amount of septic infiltrate or fluid, whether in the peritoneum or cellular tissue, will produce profound sepsis. It is in these cases that vaginal incision and drainage are indicated. We operate not to remove diseased tissues, but to drain away septic poison. The more acute the sepsis the greater the need for drainage. Also, in those cases in which the patient has weathered the storm of the acute symptoms and the case has become more or less chronic with hectic emaciation, an operation is as urgently demanded.

It may be asked why the vaginal incision is preferred to the abdominal. There are several reasons:

First. Vaginal drainage is ideal drainage. Does the vagina not carry away the waste of each monthly period and puerperium? The very structure of its epithelial lining, many-layered and resistant, makes it specially suitable for a drainage canal. The vaginal incision taps the septic focus at its base. The drainage is down hill. Gravity aids capillarity. There is no coffee pot spout arrangement that requires to be sucked out with a long-nozzle syringe at stated intervals.

Second. There is less danger of further infection. To drain septic matter through the abdomen is always hazardous, no matter how careful your aseptic precautions.

Third. The operation *per vaginam* is much easier to do.

Fourth. There being little shock at-

tending the operation, it may be done when the patient is *in extremis*. I have performed this operation when the patient was too feeble to take an anesthetic. It is truly a life-saving operation!

The dangers, other than those incident to anesthesia, are two-fold:

First. Opening a viscous, or blood vessel. This can be avoided by care. I always estimate the thickness of the upper part of the recto-vaginal septum by one finger in the rectum and one in the vagina. The median incision just behind the cervix, very short and just deep enough to go through the vaginal wall, will obviate the danger of opening either viscous or vessel.

Second. The second danger is that of opening the peritoneal cavity, thereby infecting the peritoneum. The same care and thorough asepsis will obviate this danger. I have opened the peritoneum while attempting to open a septic accumulation that was situated laterally without doing harm.

I need scarcely speak to this audience of the technique. I prefer the dorsal position. The vagina is thoroughly cleansed. If there is septic endometritis, the uterus should be curetted and packed, provided the patient can stand the additional shock and the uterus is readily accessible, neither of which condition is always present. The cervix is now pulled forward and steadied with a tenaculum. At this juncture, I sometimes employ an aspirating needle to determine positively the pressure and location of fluid, but this is not necessary in every case. With a scalpel a very short incision is made in the median line, immediately behind the cervix. Of course, if there is evidence of softening or pointing elsewhere, the incision should be made accordingly. As soon as the vaginal wall is incised, the forefinger is introduced into the opening and while the mass is steadied with the other hand on the abdomen, the finger is cautiously bored into the tissues.

If a cavity is entered, the finger is withdrawn and contents allowed to escape. If only sodden infiltrated tissues are felt, the finger is carefully forced into

the infiltrated areas, making drainage tracts for the septic infiltrate. It is immaterial as to whether the abscess or infiltrate is intra- or extra-peritoneal, the procedure is the same. I have palpated with the exploring finger the adherent coils of intestines that formed the upper and back wall of an abscess and I have palpated the distended mass from between the layers of the broad ligament. Whether free fluid or infiltrate is found, the parts are flushed with normal salt solution and packed with iodoform gauze with, in abscess cases, the addition of a rubber drainage tube. When in doubt about the exact location of the effusion, I have opened the abdomen and located it, then, with one hand in the abdomen acting as a guide, with the other made the vaginal incision.

I append a brief report of two of the worst cases of this kind on which I have done this operation.

CASE I. Mrs. W. P., residence, Waynesboro, Va. I was called to see this case in June last by the attending physician, Dr. C. A. Fox. The patient gave the following history: Aged 36, married, three children, youngest six years old. Two and a half years ago had a pelvic abscess that broke into the rectum. A year and a half ago she had cervicitis, which Dr. Fox treated and greatly benefited by local applications. On the 30th of last March (more than six weeks ago) the attending physician was called to see her and found a tender mass on the left side of the pelvis. She had pelvic pain and fever. This mass has slowly but constantly increased in size till now it nearly fills the entire pelvis. The temperature has ranged from normal to  $102^{\circ}$ , pulse very frequent and feeble. Recently she has had profuse and exhausting night sweats. She is greatly prostrated and appears very sick. An examination reveals the mass situated rather more to the left superiorly, but below it fills the entire pelvis. *Per rectum* the mass is felt pressing low down. The uterus is pushed upward and forward and the posterior vaginal fornix is bulging. No evidence of pointing can be felt or seen, but the mass has a doughy, edematous feel.

The patient was so weak that an abdominal section was out of the question, so we determined to operate *per vaginam*. Under ether the presence of pus was demonstrated by the aspiration, then a short incision was made in the posterior vaginal fornix, when 120 c.c. of sero-pus, slightly tinged with blood, escaped. This was not contained in a well defined cavity, but was like an infiltrate. The escape of this fluid reduced the mass and greatly relieved the pressure on the rectum. Now with the forefinger in the opening and between the layers of the broad ligament and the other hand in the abdomen, the left tube distended to half the size of the wrist could be easily palpated.

The wound was flushed with salt solution and packed with iodoform gauze. I advised the doctor that when she recovered from this operation and gained some strength, he should bring her to the hospital and I would remove the tube by an abdominal section. I hardly expected this woman to get better after what I did, but to my surprise she made a beautiful and uninterrupted recovery. Her temperature and pulse since fell to normal, the night sweats stopped—and in a word she got well. Recently I wrote to Dr. Fox and asked him to examine Mrs. P. and report to me her condition. His reply is so interesting in this connection that I venture to insert most of it as follows:

"I examined Mrs. P. and find some tenderness in the region of left tube and a broad band which is hard, which I suppose is nature's wall to protect the cavity where she had the abscess. It is tender only to firm pressure. She is very fat and well. The uterus is tender, due to the lacerated cervix I suppose. This ought to be operated on, as it keeps up a more or less cervicitis. Would you advise the operation, or would it be better to wait until nature removed the results of the abscess or this has been removed by operation? She is so well she would not have any operation done unless there is danger of her having another abscess."

CASE II. This patient was a mulatto woman sent into my service at the Old

Dominion Hospital by Dr. B. C. Keister of South Boston. She entered the hospital in July. She dated her trouble to her only confinement, four years ago, and has been quite sick for a year and for three months bed-ridden, suffering a great deal. Her temperature when examined was 104°, pulse 140 and very feeble. She was greatly emaciated and prostrated. The abdomen was distended and exquisitely sensitive, especially its lower half. A mass could be felt filling the pelvis and the lower abdomen to near the umbilicus. The cervix was pushed very high in front. I stated to my staff that I would not operate on her, she was so near dead; but I put her on the examining table with the view of making some further observations. After a thorough examination I was so sure that she was suffering with sepsis due to the pelvo-abdominal inflammation that I determined to make an effort to save her.

An abdominal section would have killed her surely, even a general anesthetic she could not have stood; so after applying cocaine to the posterior vaginal fornix I made a very short incision and bored the finger into the tissues. On withdrawing the finger about 50 c.c. of pus escaped. I could still feel the large mass, so I cautiously pushed the finger about in the tissues and opened into another deposit of 350 c.c. of sero-pus. Even then I could still feel a part of the mass that was supposed to be the distended tube. I did not penetrate any further, but flushed out the wound and packed it with gauze. The manipulations were so painful that I was betrayed into giving her a few whiffs of chloroform, and afterwards bitterly repented of it, for her urine became very scant, with albumen and casts. My colleague, Dr. Johnston, was present and kindly examined this case. This woman's temperature fell to 95° and for two days she was semi-comatose and delirious.

On the third day she was a little better and, to my great delight, made a splendid recovery. I saw and examined her each week. She is fat and practically well. The uterus is freely mov-

able, there is little pelvic tenderness. On the left side I can still feel the enlarged tube, but not one-fourth the size it seemed to be four months ago. If it

ever troubles her I shall remove it, which can be done with safety now; to have done so when she first came to me would have sealed her doom.

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## A CASE OF IRIDODIALYSIS, WITH OPERATION.

By Hiram Woods, M. D.,

Associate Professor of Eye and Ear Diseases, University of Maryland, Baltimore.

THE following case seems interesting enough to put on record. R. B., 25 years of age, farmer, became engaged on October 16 in a boxing match, in the course of which he received a blow in the left eye. A heavy ring was on the finger of the hand striking him. He thought it was the ring that struck his eye. I saw him October 26. Sight was lost immediately after the blow and had slowly returned.

I found an eye free from irritation: Cornea and aqueous chamber normal. A bluish-white band stretched across the anterior surface of the lens, a little below its horizontal diameter. This was the iris which had been torn away from its ciliary attachment for a distance of more than its upper half. The lower and attached iris was contracted back into the lower periphery of the anterior chamber. Here was the pupil, presenting its normal concavity below, while its superior edge was straight. Through it the fundus could be minutely studied. The pupillary opening above the iris band was nearly three times the size of that below. Through this one could see the deeper eye structures, including the peri-lenticular depressions for the ciliary bodies. These came out beautifully when the patient looked up. There was no trace of hyphema, which doubtless had caused the sudden loss of sight. Through either pupil the patient had  $\frac{2}{5}$  vision, and ability to read newspaper print. There was no monocular diplopia.

The only inconvenience suffered was the consciousness that "something was in the way of the right eye." There was no response to either light or eserine. As the patient was anxious, both for visual and cosmetic purposes,

to get rid of the "band across the sight," an operation was undertaken October 31. It was my intention to enter the anterior chamber inferiorly, because the band was below the horizontal corneal meridian, and the portion of the uninjured iris would give protection to the lens capsule; seize the detached portion at its middle and excise as much as possible.

I asked Professor Chisolm to see the case with me, however, and he suggested that a better cosmetic, and, unless the capsule were injured, an equally good visual result would follow a successful attempt to replace the pupil by drawing the attached portion into a wound at the limbus, bringing enough of it out through the wound to make it secure. This amounted practically to Mr. Critchett's "iridodesis" operation, minus the silk loop. The ease with which eyes tolerate, after simple cataract extraction, such little iritic protrusions as would thus be produced seemed to both of us an argument for the safety of the procedure.

I made a small opening into the anterior chamber superiorly, starting a little behind the limbus in the sclerotic. The detached iris was seized with some difficulty, as it fell before the forceps. It was secured at the second attempt and drawn into the wound until the iris was in its natural position. Atropia and a single protective bandage completed the operation. There was no reaction, the lens remained clear, and when the patient left the hospital, November 5, the eye presented the appearance of complete mydriasis. Distant vision was  $\frac{2}{5}$ . A convex lens to neutralize the atropia enabled him to read Jaeger No. 1.

## Society Reports.

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### THE GASTRO-ENTEROLOGICAL SOCIETY OF BALTIMORE, MD.

MEETING HELD DECEMBER 14, 1895.

The regular meeting of this society was held at the residence of Dr. Henry Salzer.

*Dr. Salzer* read a paper entitled ON THE USE OF TEST-MEALS. He advocates for general use the following combined test-meal: For breakfast the patient receives 30 grammes of lean, cold roast, cut into strips sufficiently small as not to obstruct the lumen of the stomach tube, 250 c.c. of milk, 60 grammes of rice, and one soft-boiled egg.

Exactly four hours later the second meal is taken, consisting of from 35-70 grammes of stale wheat bread and 300-400 c.c. of water. One hour after the exhibition of this second meal the tube is introduced and withdrawn together with its contents almost immediately. An amount of material sufficient for analytical purposes, as far as qualitative tests are concerned, is thus obtained. In the case of a normal stomach no remnants of the first meal will be found, while a motor insufficiency can be diagnosed at once, if particles of meat or flakes of casein are obtained. In the discussion which followed—

*Dr. Simon* stated that he had used the combined test-meal of Salzer during the last three years and could endorse its superiority over the usual test-meals of Ewald and Riegel. Frequently patients will submit to the ordeal of the stomach tube but once, and no opportunity is afforded for the separate determination of the secretory and motor power of the stomach.

*Dr. Friedenwald* suggested the advisability of carefully determining the normal curve of acidity after Salzer's meal.

*Dr. Salzer* stated that he found a slightly higher degree of acidity after his test-meal than after that of Ewald.

*Dr. Salzer* further reported A CASE OF PYLORIC STENOSIS, occurring in a young colored woman, in which the amount of urine voided in the twenty-four hours varied between 1500 and 2500

c.c., suddenly falling to 600 c.c. three days before the operation of gastro-enterostomy was performed. Death resulted a few days later. Post-mortem examination revealed the existence of a tumor of the pylorus. Microscopic examination showed a small round-celled infiltration.

*Dr. J. Friedenwald* reported a case of GASTRO-ENTEROSTOMY in which death occurred two months later from peritonitis, owing to the impaction of Murphy's button in the transverse colon.

*Dr. Simon* reported a case of PYLORIC STENOSIS, referable to carcinoma, in a woman, aged 56. Vomiting and epigastric pains had occurred during three years. The loss of flesh was trivial. Examination of the gastric contents showed the absence of free hydrochloric acid; total acidity, 48. Following Boas' test-meal, large amounts of lactic acid were obtained. Pepsin, pepsinogen and chymosin absent; chymosinogen present in greatly diminished amount. No remnants of previous meals. Physical examination showed the large curvature of the stomach at the symphysis. A hard tumor could be felt in the epigastric region. The urine was light-yellow in color, presenting a specific gravity of 1012; there was no increase in the amount of indican. This case is of especial interest, showing the perfect manner in which small intestinal digestion is capable of replacing gastric digestion, providing the motor power of the stomach be unimpaired. The absence of the indican reaction is very exceptional, as the degree of indicanuria usually observed in cases of carcinoma of the stomach is surpassed in intensity only by that observed in cases of ileus.

*Dr. Salzer* suggested that the absence of indicanuria was probably explained by the excellent motor power of the stomach.

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THE SOUND AND ABORTION.—The uterine sound should never be passed until the patient has been under observation for at least a month and even then it is better to do it immediately after a menstrual period.

## Medical Progress.

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SERUM TREATMENT OF CANCER.—At a recent meeting of the Académie des Sciences (*British Medical Journal*) Richet and Héricourt presented a further report on the treatment of cancer by serum. Since their first communication on the subject they had been able to study the effects of the treatment in a much larger number of cases. Their own observations, together with those communicated to them by Reclus, Pinard, Terrier, Faure, Hallopeau, Tuffier and others, amounting altogether to about 50 cases, led them to the following conclusions: 1. A very marked diminution of pain follows the injections; this effect had not been expected. 2. Cancerous ulcers become clean and assume the aspect of granulating sores, and may even heal over a fairly large extent of surface. 3. Marked shrinking takes place not only in the neighboring tissues and related glands, but in the growth itself. In some cases the development of the disease is checked and the general condition is distinctly improved. To sum up: In four-fifths of the cases a real improvement is beyond question, but a complete cure is not brought about. After a month or two new cancerous foci appear, and the disease goes on and ends in death. Is the serum specific or not? The authors find it difficult to give a definite answer to this question. The results seen in two cases, however, make them incline to the belief that the serum of immunized animals is much more active than that of healthy ones. In two cases also the serum seemed to have some effect in preventing recurrence, and they suggest to surgeons a trial of a combination of this treatment with the usual operative measures.

\* \* \*

PERITONEAL ADHESIONS SEPARATED BY POSTERIOR AND ANTERIOR COLPOTOMY.—Boisleux of Paris has, since 1891, practiced vaginal section by making a vertical incision into the posterior cul-de-sac. By this means he avoids injuring the utero-sacral ligaments. The utero-sacral ligaments, according to Schultze and Winckel (*American Gynecological and Obstetrical Journal*), are the strongest supports of the uterus and it is therefore of great advantage to preserve their integrity. By posterior colpotomy adhesions may be broken up by introducing the finger into the peritoneal cavity, pus accumulations may be evacuated, malpositions fixed by adhesions may be corrected; diagnoses in doubtful cases may be established and ovariotomy may be performed through this incision. Anterior colpotomy (Duhrssen-Mackenrodt operation) consists in making a longitudinal incision in the median line of the anterior wall of the vagina, commencing about an inch from the urethra and extending to the vagino-cervical junction. By careful dissection the bladder wall is separated from the anterior wall of the uterus until the vesico-uterine pouch is reached. This pouch is then opened and the uterus anteverted, the fundus appearing in the incision. Two sutures are now passed from the anterior vaginal wall on the left side of the incision through the fundus of the uterus, coming out through the right side of the anterior wall at a point opposite its entrance on the other side of the incision. These sutures are then tied and the uterus is thus prevented from again falling backward. This operation also permits of the examination of the diseased appendages and the removal of small fibroids. It is not applicable to cases of retroversion with adhesions. In these cases the adhesions are broken up by posterior colpotomy, the uterus placed in a position of anteversion and the operation then performed as described.

\* \* \*

OYSTER SHUCKER'S KERATITIS.—In the *Johns Hopkins Hospital Bulletin*, Dr. Robert L. Randolph describes this local trouble. Few cases are found outside of Baltimore, because of the great oyster industry in this city and also because the shuckers here usually break off the edge of the shell with a hammer. The disease is strictly of traumatic origin. There is marked photophobia.

The best treatment is obtained by the use of a compress bandage and a mild sublimate solution ( $\frac{1}{4000}$ ) used every

four hours, together with an occasional drop of a solution of atropia (one per cent.). His conclusions are :

1. Oyster shucker's keratitis may be defined as a traumatic keratitis where the injury is produced by a particle of the oyster shell.

2. The disease is chiefly remarkable for the rapidity with which the cornea undergoes necrosis at the site of the injury, this area of necrosis being usually very small, owing no doubt to the small size of the foreign body. Small foreign bodies of copper, steel and sand usually produce no appreciable keratitis; and even when they lodge in the cornea, commonly require several days to cause a noticeable inflammation. On the other hand, the oyster shucker presents a marked infiltration of the cornea at the point of injury within twenty-four hours after the accident.

3. This decided reaction on the part of the cornea makes the injury a peculiarly dangerous one when a large area is wounded, or when entrance has been made into the anterior chamber, such conditions in my experience being invariably followed by loss of the eye through panophthalmitis. How often do we see the cornea injured in the same degree by other kinds of foreign bodies and still the vision not entirely destroyed.

4. Bacteriological investigations failed to discover any specific organism, nor did any of the organisms obtained from cases of oyster shucker's keratitis manifest any pathogenic properties when introduced into the cornea of rabbits, with the exception of the pyogenic cocci. It is not likely then that the disease is of parasitic origin.

5. The carbonate of lime, of which the oyster shell is almost entirely composed, was found to possess qualities irritating enough to call forth a keratitis when introduced into the cornea of a rabbit, and it is more than probable that several other chemical ingredients of the shell would be more or less irritating to the cornea.

6. It is certain that bacteria always play a part in traumatic keratitis, but it is evident that in this variety of traum-

atic keratitis the cornea is rendered especially susceptible to the effects of micro-organisms, by the irritating chemical ingredients of the oyster shell, notably the carbonate of lime.

\* \* \*

PERITONEAL ADHESIONS AFTER LAPAROTOMY.—In a paper with this title (*American Gynecological and Obstetrical Journal*) the author, Dr. Byron Robinson, offers the following conclusions :

1. Operations for peritoneal adhesions are seldom ever required when the adhesions surround solid or fixed organs.

2. The major peritonitic regions—the appendicular, the gall bladder, the sigmoid regions—seldom ever demand operations for peritonitic adhesions. The fourth major peritonitic—the pelvic region—seldom requires an operation for peritonitic adhesions around the uterus itself.

3. The peritonitic adhesions in the pelvis which demand operation are those involving the loops of small intestines, sigmoid, bladder, or Fallopian tubes.

4. Peritonitic adhesions requiring operation are those which involve the most movable organs which possess peristalsis.

5. The peristaltic motion of the adherent loops of small intestines, the sigmoid, the Fallopian tubes, and the bladder, is what produces pain.

6. The pain is a dull, dragging pain, exacerbated by motion, defecation, and urination, if the bladder is adherent.

7. The stumps of the Fallopian tubes are the most frequent points of adhesion. This is due to the mucous membrane of the tube being left exposed to the peritoneal cavity, and no doubt recurrent flows of infection trickle out of the end of the tube and can keep up its recurrent attacks after the adhesions are formed.

8. The mucous membrane of the Fallopian tube should be buried with a suture, scooped out of the cornua of the uterus, or covered with peritoneum.

9. The ligature should not be put around the tube, but simply around the ovarian artery.

10. No doubt catharsis at the end of the second day produces sufficient peris-

talsis to free many coils of intestine from the bed of soft exudate.

11. It does not appear from these seven cases that drainage increased the peritoneal adhesions. In fact, the most of these cases were not drained, and by far the worst cases were those not drained at the first operation.

12. The great prophylaxis in these cases is to cut off the open connection between the uterus and the pelvic peritoneum by burying in some way the stump of the Fallopian tube.

13. In several of these cases nearly two years after the first operation, as far as the eye could detect, the lumen of the Fallopian tubes was not closed, and the mucous membrane was thus exposed with its open lumen to the peritoneal cavity—in surgery a chance to keep up the old infection which demanded the first operation. The tubes must not only be removed, but the tubal lumen must be closed and shut off from the peritoneal cavity. Of course the final prophylaxis is what we are now doing, and that is removal of the uterus for bilateral disease of the appendages.

\* \* \*

**RENAL CALCULUS IN WOMEN.**—Errors frequently occur in attempting to make a diagnosis of renal calculus in women. The presence of pus and blood may lead to a further examination, but, as Dr. Howard A. Kelly says in the *Medical News*, it cannot be told which kidney is affected until each ureter is in turn catheterized.

A rubber catheter with a wire stylet can be introduced by Kelly's method through the bladder. He has been able by direct catheterization to establish the following points :

1. By renal catheters to demonstrate a unilateral or a bilateral pyelitis and the grade of each.

2. By suction at the outer end of the catheter to bring down bits of stone for microscopic and microchemic examination.

3. The color of these pieces of stone signified a long retention in the pelvis of the kidney.

4. A piece of stone, black, rounded on one side and light-colored and jag-

ged on the opposite, was evidently broken off from a larger calculus and caught in the eye of the catheter by friction and suction.

5. The bruised end of the catheter was conclusive evidence of violent contact with a hard body.

\* \* \*

**PUERPERAL FEVER.**—Rapin (*British Medical Journal*) denies that there is such a thing as puerperal fever without local lesions. Practically the disease begins as septic endometritis. The acute so-called "unlocalized" form is always rapidly fatal, so that no clear naked-eye changes can be detected in the infected endometrium. In a few slower cases definite pyemic changes are observed; the disease is then rather acute septicemia or pyemia than fever. The chronic "unlocalized" form of puerperal fever is much milder; most cases of recovery belong to this type. The endometrium is always inflamed and septic, but the inflammatory process is locally mild, passing off before general symptoms are observed. The fever is due to intoxication, not infection. Toxines develop in the inflamed mucosa and pass into the blood. Microbes, Rapin insists, may enter the blood, but they are destroyed by phagocytosis or by the bactericide action of the blood, in this form of fever. Thus chronic puerperal fever, "without localization," is really chronic septic puerperal endometritis, the general rapidly replacing the local symptoms. The importance of the early use of the curette becomes evident.

\* \* \*

**HORSE SERUM INJECTIONS.**—In speaking of the effects of horse serum injections, in the *Medical Record*, Dr. Henry Dwight Chapin says that the final verdict upon serum injections and serum therapy must rest upon clinical, rather than laboratory, evidence. Studies in the laboratory thus far made warn us to use this powerful agent carefully. If prolonged and careful clinical observations made under varying conditions and by different observers prove its utility, serum therapy, in spite of possible dangers, will have a brilliant fu-

ture. Research in the line of separating the antitoxines, so that they may be given in an innocuous vehicle, or highly concentrating them in small quantities of serum, seems to be the next step desirable.

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**THE INCOMES OF PATIENTS AND MEDICAL CHARGES.**—The *Lancet* says there are certain rules by which a medical man is guided in charging his patients. We should be sorry to see him become a sort of assessor of income-tax. We should disapprove as alike impossible and undignified any minute scrutiny into the particulars of a patient's means. The amount of his rent is a guide to his position, but only a rough one, and one not to be made too much of. On the whole a medical man does best to be guided by a sense of a value of his own services to the patient, without attempting to differentiate him from other patients and making a separate tariff for each. A man with a high rent may be practically much less able to pay than one with half the rent, and there are the greatest objections—which we cannot specify here—to a medical man speculating on the income of his patients. Questions of distance, trouble, night work and anxiety are all fair elements for consideration. But the question of particular income does not arise save to check any tendency to undercharge or overcharge, by either of which a medical man often does himself much harm.

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**DIGITALIS IN PNEUMONIA.**—Dr. Hans Naegeli-Akerblom, in the *Therapeutic Gazette*, in discussing the treatment of croupous pneumonia with digitalis draws the following conclusions :

1. Digitalis is one of our most important therapeutic agents in combating croupous pneumonia.
2. It acts favorably upon the heart, lungs and blood.
3. In large doses it abbreviates the duration of pneumonia.
4. In large doses it acts especially favorably on the increase of the leucocytes, the polynuclear cells. Single doses of 1 grain, and daily doses up to 4 or 5 grains, are borne without injury.

5. The employment of cold water is combined most practically with the digitalis treatment, as thereby hyperleucocytosis is developed.

\* \*

**THE RADICAL CURE OF UMBILICAL HERNIA.**—Tillaux (*American Journal of the Medical Sciences*) describes a modification devised by his assistant, Dauriac. The method consists in making two longitudinal incisions in the recti muscles in the middle third of their length, dividing them into two bands. The internal bands, including the anterior portion of their sheaths, are divided transversely at their superior extremities, while the two external portions remain to preserve the continuity of the recti. After their detachment the two bands are much less retracted ; this permits of their being crossed over the point where the umbilical opening formerly existed. Their superior extremities are thus transposed, each uniting with the rectus of the opposite side, at the point where the other was removed.

\* \*

**ANTIPHTHISIN.**—Drs. E. L. Trudeau and E. R. Baldwin of Saranac Lake have made an investigation, the results of which are recorded in the *Medical Record*, on the efficacy of Klebs' antiphthisin. They reach the following conclusions :

The substance made according to Klebs' published method, and called by him antiphthisin, resembles deuterolalbumoses in its chemical reactions, and can be precipitated by sodium-bismuth-iodide. Hence it has no peculiarity of behavior to that reagent to distinguish it, and as a similar substance can be obtained from unplanted bouillon it cannot be considered an altogether specific product of the tubercle bacillus.

1. Antiphthisin prepared according to Klebs' published method is practically highly diluted tuberculin, and its physiological effect on animals, when given in sufficient doses, is the same as tuberculin.

2. Antiphthisin possesses, under the conditions stated above, no germicidal power on the tubercle bacillus which can be demonstrated *in vitro*.

3. When applied to animals, as stated above, neither tuberculocidin nor anti-phthisin had any curative influence over the course of experimental tuberculosis in the guinea-pig.

4. Since cultures of the tubercle bacillus become acid as they grow, and, furthermore, since the addition without heat of a little alkali to a filtered culture medium upon which bacilli have ceased to grow renders it again fit for the development of a second crop of germs so long as any nutrient remains, it may be inferred that the limitation of the growth of the tubercle bacillus in such a culture medium is most likely due to the acidity induced in the medium, rather than to any specific germicidal substance produced therein.

\* \* \*

**CONTAGION IN THE DAIRY.**—In order to ensure the local extinction of infectious disease, says the *Lancet*, it is not sufficient to apply any one routine formula of treatment. Sanitary science is not, however, by any means a subject of purely technical character, but one which is to a large extent comprehensible by the general intelligence. For this reason the necessary safeguards, which are its practical evidences, must also be numbered among the duties of the private citizen. It follows that a milk-dealer convicted a few days ago at the Thames Police Court was liable for an offence in selling milk while his household premises, used also for trading purposes, were contaminated by diphtheria. The defence in this case was that of ignorance, and as such was insufficient to justify acquittal. It is, however, suggestive as bearing on other and related considerations. The disease was duly notified by a practitioner. It proved fatal in two days. Six days subsequently disinfection was carried out. In the meantime the milk trade went on, the salesman being, as alleged, ignorant as to what this implied to his customers. There are instances, of course, and these not few, in which the seclusion of the infected and the pursuit of a calling may be possible in the same establishment at the same time. The present case was evidently not of such a

kind, yet the patient was not removed, and the dealer did not know that he should suspend his business. It is, to our mind, somewhat surprising that he should have been without instruction in a matter so important after a visit from the sanitary officer. Surely the work of inspection, though it cannot supersede the demand of the law, is understood to provide for such instruction where occasion requires.

\* \* \*

**WOMAN'S MEDICAL CLUB.**—The first anniversary of the Woman's Medical Club of Chicago, says the *American Medical Review*, reminds us again of the fact that women's clubs continue to multiply and flourish and gain respectful recognition, despite the suspicions of curious husbands, who were inclined to subject them to critical inspection when they first began to see light; and they have reached a point, too, where they represent as much diversity in tone as the man's club. This medical club, formed one year ago, was the first one of the kind ever organized. Chicago, with the suburbs, claims two hundred and fifty women doctors, and many of those among the younger women are fitted to be surgeons.

## Correspondence.

### A BIT OF HISTORY.

Editor MARYLAND MEDICAL JOURNAL:

Dear Sir:—Here is a curious bit of historical medicine which I ran across some time ago. It is translated from the German of Dr. Hans Ferdy, Berlin, 1892:

"As the first four years of Maria Theresia's married life were childless there was a consultation of physicians and the great Van Swieten gave the celebrated as well as successful advice: "*Ego vero censeo vulvam Sacratissimae Majestatis ante coitum diutius esse titillandum.*" The reigning house of the Hapsburgs is apparently the result of this advice.

Yours truly,

ROBERT B. MORISON.

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BALTIMORE, JANUARY 18, 1896.

THE formal opening of the new library and hall of the Medical and Chirurgical Faculty of Maryland last Saturday

*The Faculty's House-Warming.* night marks another epoch in the life of that venerable institution.

After most zealous and generous efforts on the part of the trustees, the committee in charge and many liberal friends and members of the Faculty, the trustees were enabled to open last Saturday night the new hall and building which now belongs to the State Society and is a permanent home for the library and will be in a measure a medical club for the profession of Baltimore and Maryland. The exercises last Saturday night were most carefully carried out and were a source of congratulation for the members.

Through the liberality of Dr. William Osler the whole building was handsomely decorated with potted plants, palms and running vines and over the rostrum was the American flag. The exercises opened with remarks by the

President of the Faculty, Dr. Charles G. Hill, then followed remarks by Dr. L. McLane Tiffany, president of the board of trustees, and then a statement by Dr. Thomas A. Ashby, treasurer of the board of trustees.

After this the orator of the evening, Dr. James R. Chadwick of the Boston Library Association, who came on especially for the occasion, delivered his address on "Medical Libraries." This address together with full details of the meeting will be published in a later issue of the JOURNAL, but it should be noted here that the inspiring words of Dr. Chadwick, who showed the difficulties of establishing medical libraries and how these difficulties could be overcome, and what is more, his initiatory offer to contribute to the Faculty's fund provided others present would follow his example, aroused such enthusiasm that in a few minutes between three and four thousand dollars had been subscribed.

Later, Surgeon-General George M. Sternberg and Dr. Robert Fletcher of the United States Army made addresses, and in the absence of Dr. John S. Billings Dr. Osler made a few pertinent remarks. The evening closed with a most sumptuous collation, to which the large number present did ample justice.

The idea suggested in the last issue that each local society should contribute books to the shelves of the library was also approved. The interest which was so thoroughly aroused last week in the Faculty and its library should not be allowed to subside. The attractive quarters will be the means of bringing in new members; and the library, which contains a large journal list and books old and new, will afford additional field for the readers and those interested in research.

Articles have been promised for this JOURNAL on the old and valuable books in the library and one member of the Faculty is about to publish a catalogue of all the medical books in Baltimore in public and private libraries.

It might be fitting to bestow especial praise on one or two men in the Faculty who for years have worked unselfishly for the promotion of the society, but each one knows just what part he has contributed and feels fully repaid at the results exhibited last Saturday night. This interest must be kept up; members should use the library and the nurses' directory.

Members of the profession not members of the Faculty are invited to look over the build-

ing at any time. The library is open from 10 A. M. to 8 P. M.; the nurses' directory about the same hours. The work begun last week should be kept up and each member of the Faculty should feel a personal interest in its welfare and should work for its prosperity.

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ALTHOUGH the health report of Baltimore for the past year has not been issued, some of

the salient points of that

*The City's Health.* report may be of interest.

The Health Commissioner still continues to make the same recommendations to the Mayor and City Council and it is likely that his persistency will be rewarded and he will see his fondest hopes fulfilled.

He urges the necessity of a hospital for the treatment of infectious diseases, a local disinfecting plant and biological laboratory, as well as a more stringent law on the subject of dairy inspection, but the principal recommendations refer to the city's water supply.

The analysis made under his supervision, as well as frequent inspections of the watershed, have convinced him that the prevalence of typhoid fever throughout the city during the past six months was largely due to pollution of the water supply, and apparently little of the trouble can be remedied for the time being.

Figuring on the city's future growth, and taking present conditions into consideration, Dr. McShane thinks that efforts to purify city water should be made mostly along the Gunpowder. That stream, he said, would be the main source of supply in years to come, and his plan would be to have the city acquire by condemnation proceedings the land on both sides of the river for a distance of an eighth or a fourth of a mile from the banks. Then he would plant trees, he said, and the result would no doubt prove the advisability of the outlay, which might be from \$500,000 to \$1,000,000.

During December the milk inspectors of the Health Department examined 10,339 gallons of milk and spilled 458. They also examined 226 dairy stables, containing 1368 cows, and found fully 98 per cent. of them in a condition not conducive to the production of pure milk. The Health Department has no power to remedy matters, however, until the Council passes a more stringent ordinance.

The Mayor is said to be still undecided in his choice for a health commissioner and assistant health commissioner, probably because in the list of applicants such good names are found. The copybook says that "experience teaches all things" and it is well known that the present health commissioner is a man of wide experience in matters relating to health and in his knowledge of contagious diseases and epidemics.

If report is true the Mayor will call a meeting of physicians to consider the health of the city in which he has shown the liveliest interest.

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AT a meeting of the Royal College of Physicians of London held last October the attempt to admit women to *Women the licentiate* was brought up and defeated and Dr. Charles West in support of this defeat stated that up to one hundred and fifty years ago one department, namely, midwifery, had been entirely in the hands of women, but they had done absolutely nothing to advance its practice, and it had been left to a man, Ambroise Paré, to introduce turning, whilst the invention of the forceps had been due also to a man, Chamberlen.

In America women had practiced medicine for fifty years but he was not aware that they had made any contribution to our knowledge, and in the subject of children, which was supposed to be one for the study of which they were particularly adapted, he had failed to find any contribution to practical medicine made by a woman. He continued in this strain for some length of time and those in favor of the admission of the women brought up equally strong arguments, but in the matter of a vote it was found that the women were refused admission by a vote of 50 to 59, the women being defeated by a majority of nine. The conservatism of England is hard to break down but the close vote shows that the gentle sex has more friends in that country than one would have believed.

Women in America have entered the ranks of the profession and in many cases have achieved a marked success but the shining lights of that success are not many in proportion to the large number of women who are practicing medicine.

## Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending January 11, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		22
Phthisis Pulmonalis.....		28
Measles.....	99	2
Whooping Cough.....	8	1
Pseudo-membranous Croup and Diphtheria. }	14	6
Mumps.....	1	
Scarlet fever.....	10	
Varioloid.....		
Varicella.....		
Typhoid fever.....	2	1

Dr. John S. Billings has been chosen librarian of the Consolidated Libraries of New York City.

The World's Congress of Medico-Climatology will be held at San Antonio, Texas, February 20, 21 and 22, 1896.

Mr. George S. Davis, the publisher of the *Index Medicus*, is anxious to obtain copies of the number for January, 1893.

The students of the College of Physicians and Surgeons of Chicago publish a monthly journal called *The P. and S. Plexus*.

Dr. Warren Webster, a distinguished physician and retired Major-General United States Army, died last Monday in Baltimore. Dr. Webster was a graduate of Harvard.

A large brass tablet, suitably inscribed, has been placed in the main hall of the Baltimore Medical College by the faculty of that institution in memory of the late Dr. Edmund R. Walker.

A bill has again been presented to the House of Representatives to pay the legal heirs of the late Dr. John W. Branham, Assistant Surgeon United States Marine Hospital Service, who died at his post of duty of yellow fever in 1893, the amount of his pay and allowance for two years.

The death is announced of Dr. A. W. Thompson, a recent graduate of the University of Maryland. Dr. Thompson served as assistant resident physician at the University

Hospital, then resident at the Union Protestant Infirmary and at the time of his death was a member of the United States Engineering Corps. He was twenty-seven years old and a native of Kent Island, Maryland.

The Mayor has appointed Dr. Henry M. Hurd of the Johns Hopkins Hospital and Dr. George A. Hartman on the board of trustees of Bay View Hospital. Dr. Hartman has accepted, but Dr. Hurd will not be able to serve.

Among the journalistic notes for 1896 may be remarked the removal of the *Medical News* from Philadelphia to New York; the new typographical dress of the *Medical Record*, the *American Medico-Surgical Bulletin* and the *Medical Brief*; the change of name of the *Abstract of Sanitary Reports to Public Health Reports*, and two new publications, the *Southwestern Medical Record* of Houston, Texas, and the *Peoria Medical Journal* of Peoria, Illinois.

There has been started in Baltimore, from funds obtained by private subscription, a new and excellent charity—the district nursing of the sick among the very poor by a trained nurse. The work will be somewhat in the line followed by the deaconess' orders of the various churches, save that it is done by a graduate of a hospital training school. The nurse for eight hours each day will visit from house to house in the district to which she is assigned, staying only long enough to tide over critical points, or direct what shall be done in her absence or give an hour or two's respite to worn-out watchers by the sick-bed. There are many cases where it is not expedient or wise to remove invalids to a hospital and where the family prefer to pay a small sum rather than become objects of charity. Such cases will come within the scope of the district nurse, while in cases of great poverty no payment will be desired or expected. Cases where great want as well as illness exists will be reported by the nurse to church societies or charitable institutions, and she will work under the direction of physicians of free dispensaries of the neighborhood. The plan has been eminently successful in other cities, and the organization hopes for voluntary support in Baltimore. The present nurse is Miss Evelyn Pope, a graduate of the Johns Hopkins Training School for Nurses. The work has been begun at 1203 South Charles Street.

## WASHINGTON NOTES.

The regular meeting of the Medical Society of the District of Columbia was held on Wednesday evening, January 8, the President, Dr. Samuel C. Busey, in the chair. Dr. Sterling Ruffin read an essay on "The Treatment of Typhoid Fever." Dr. T. E. McArdle presented "A Case and Specimen of Osteo-Sarcoma of the Foot."

The Clinico-Pathological Society held its regular meeting on Tuesday evening, January 7, Dr. H. B. Deale in the chair. Dr. W. H. Wilmer read an interesting paper entitled "Injuries of the Eyeball."

A regular meeting of the Executive Committee of the Central Dispensary and Emergency Hospital was held at the Hospital on Friday, January 10. Much important business was transacted. It was ordered that the words, "Students of Georgetown College," should be inscribed on the new marble tablet, on which the names of those who had furnished rooms in the Hospital have been carved.

We are indebted to the Health Department for the following: The death rate of the city for the week ending January 4 was very low, being a fall of 27 per cent. as compared with the number of deaths reported at the Health Department the previous week. The total deaths were 78 and the annual death rate for the whole population declined to 14.7. The improvement was all along the line. The mortality from acute lung disease and from consumption was 40 per cent. less than by the last report. But one death from typhoid fever was reported; none from scarlet fever; four deaths from diphtheria, being a moderate increase, which took place during the latter part of December.

## Book Reviews.

INDEX-CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE, U. S. A. Vol. XVI. W-Zythus. Washington: Government Printing Office, 1895.

With this volume, the first series of the Index-Catalogue ends. The volume contains 12,759 author-titles, representing 4857 volumes and 11,613 pamphlets. It also contains 8312 subject-titles of separate books and pamphlets and 13,280 titles of articles in periodicals. In the entire series of sixteen volumes there are

176,364 author-titles, representing 85,663 volumes, and 151,504 pamphlets; 168,557 subject-titles of books, and 511,112 titles of articles in journals; also 4335 portraits all in Volume III.

Nothing is needed further than this enumeration to give those who are not familiar with the work an idea of its vastness and completeness. It owes its existence and completeness to the genius of Dr. John S. Billings, who in 1876 conceived it and who has amidst many discouragements and hindrances carried it to a successful termination.

Practically the library of the Surgeon-General's office has been built up in the last 35 years. In 1876 there were about 52,000 books and pamphlets and now the number has increased to 116,847 books and 191,598 pamphlets. One-sixth of this number has been donated or given in exchange, and the names of the most liberal donors are published with grateful acknowledgment. A considerable portion of the additions during the past sixteen years has been derived from the exchange list of the *Index Medicus* and books sent for description in that periodical, which its editors have presented to the library. First of all (after Dr. Billings, of course) Dr. Robert Fletcher, the assistant editor, is to be praised, to whom the accuracy and typographical excellence of the volumes are largely due. Then there has been proof-reading by Drs. Rice, Chadwick and Yarrow, clerical work far beyond mere routine by the clerks of the library, indexing of the files of periodicals by various medical officers of the army who were detailed upon request for that purpose, and finally the printing of the work at the Government Printing Office under the direction of Captain H. T. Brian.

A list of corrigenda, 14 pages in all, a surprisingly small amount, considering the nature and size of the work, concludes this volume. These are errors of commission only, those of omission being reserved for the new series. And with reference to this new series we learn that the manuscript of a second series, including all the titles of books and articles received too late for insertion in the first, has been prepared and will make about five volumes, and that the work of printing these complementary volumes will proceed without interruption, Congress having granted the appropriation needed for printing Volume I, and confidence being felt that the

additional amount will be forthcoming when needed. Of course, no such work as this could have been accomplished without governmental aid and Dr. Billings acknowledges the debt due to those who have aided in securing the needed appropriations.

**MAISCH'S MATERIA MEDICA.** New (6th) Edition. A Manual of Organic Materia Medica. Being a guide to Materia Medica of the Vegetable and Animal Kingdoms. For the use of Students, Druggists, Pharmacists and Physicians. By John M. Maisch, Phar. D., Professor of Materia Medica and Botany in the Philadelphia College of Pharmacy. New (sixth) edition, thoroughly revised by H. C. C. Maisch, Ph. G. In one very handsome 12mo. volume of 509 pages, with 285 engravings. Cloth, \$3.00. Philadelphia: Lea Brothers & Co. 1895.

This work of perhaps the foremost of American pharmacists, the late Professor Maisch, has become a high authority upon the subject of which it treats and successive additions have added to its value. The present editor has worthily stepped into the place of his father and in the present revision, necessitated by the appearance of the U. S. Pharmacopeia, has rendered the work still more worthy of favor. For students of pharmacy it is indispensable and we may say the same of students of medicine unless we take the narrow view that only that minimum of information is needed by them which will enable them to "get through" and to follow their profession along exclusively "practical" lines.

#### REPRINTS, ETC., RECEIVED.

II Solfo-Ittiolato d'Ammonio nella Suppurazione. By Dott. Adolfo Liscia of Leghorn, Italy.

University of Maryland. Eighty-ninth Annual Announcement of the School of Medicine. 1895-1896.

The Infiltration Method of Local Anesthesia in Genito-Urinary Surgery. By Bransford Lewis, M. D., of St. Louis.

Ichthyol bei Epidymitis Gonorrhoeica. By Dr. S. Maylander of Fiume. Reprint from the *Pester Medizinisch-Chirurgische Presse*.

Die Behandlung der Lungentuberkulose mit Ichthyol, von Dr. L. Guido Scarpa of Turin, Italy. Reprint from the *Therapeutische Wochenschrift*.

#### Current Editorial Comment.

##### SHORT-HAND IN MEDICINE.

###### *Medical Record.*

THE need for writing, for a written record, is absolute in medicine as in every science that rests on observation, for memory cannot be trusted, and immediate record can alone make observation effective. But with the aid of short-hand twice the amount of record that is possible with long-hand can be made, and yet there will remain a longer time in which to observe. Furthermore, many fleeting events which might escape record in long-hand can be noted and preserved in memory forever by the winged characters of phonography.

##### THE BUSINESS OF MEDICINE.

###### *Lancet.*

IT is a lamentable fact that the training of many a modern scientific student does little to fit him for the practical duties of his profession, especially in its business aspects. The advice not uncommonly given by senior members of the profession to juniors just emerged as fully fledged practitioners is somewhat as follows: "Now you have passed your examinations, go and learn your profession by acting as assistant." Be this as it may, many young consultants and practitioners are strangely deficient in even that rudimentary business capacity which would be essential towards the successful conduct of any other occupation or profession.

##### MEDICAL TERMINOLOGY.

###### *American Medico-Surgical Bulletin.*

MOST of the medical words are at present created more or less correctly on etymological principles. But many of the words which are in current use today were formed at a time when medicine was less advanced; and they reveal to us, very quaintly, opinions of the faculty which were then received with respect, but which subsequent research has proved to be erroneous. Any attempt which has for its object the eradication of words which have been handed down through medical generations must be regarded as hopeless. Montaigne, writing in his brusque way on this subject, is very uncomplimentary to persons who try to fight custom with grammar.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

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### MEMORIAL ADDRESS

DELIVERED AT THE UNVEILING OF A MURAL BRASS TABLET, PLACED IN THE AMPHITHEATRE  
OF THE BALTIMORE MEDICAL COLLEGE, JANUARY 9, 1896, BY THE FACULTY, TO THE  
MEMORY OF DR. EDMUND RHETT WALKER.

*By S. K. Merrick, M. D.,*

Professor of Diseases of the Nose, Throat and Chest, Baltimore Medical College.

GENTLEMEN of the Faculty, Ladies and Gentlemen:—I am here this evening in the capacity of biographer by resolution of the faculty, simply because I was one of the closest friends of the man whose memory we are here tonight to honor. The pains I have taken to prepare this imperfect sketch have been a labor of love.

Dr. Edmund Rhett Walker was born in Beaufort, South Carolina, July 13, 1836, and died in Baltimore, September 30, 1891. In 1863 he married Miss Jane Lewis Perkins of Virginia, who was his devoted companion through life. She, together with a daughter and son, survive him, the former the wife of the Rev. A. H. Miller, an Episcopal clergyman of Philadelphia; the latter, Mr. Joseph Walker, is just 22 years old and holds a responsible position with the Mercantile Trust and Deposit Company of this city. Dr. Walker left also a brother, Rev. Albert R. Walker, rector of Calvary Protestant Episcopal Church, Wilmington, Delaware, who possesses in no small degree the learning and piety which have distinguished the family for generations. Two sisters also survive him.

Dr. Walker was the eldest son of the late Rev. Joseph R. Walker, rector of the Episcopal Church in Beaufort, South Carolina, for 57 years, a service with few parallels in the history of the church in this country. He died only a few years since, in his 83rd year, having been an ordained minister for 62 years. I knew him in the decline of life; he was then well-preserved, fine-looking and agreeable. But an oil painting of him, executed when he was in the prime of life, is in possession of the family, which shows him to have been a remarkably handsome man, with a face at once sweet, benevolent and strong. His congregation in Beaufort almost idolized him and no stronger proof of this is needed than the 57 years of continuous service as their rector. He was himself descended from three generations of clergymen in the Church of England in America. Beaufort was a place in ante-bellum days (at least) of much culture and refinement and no ordinary man could have pleased this people so long and so well. He was not only a man of intellect, but a man of great piety.

On his mother's side the subject of

this sketch, Dr. Walker, was descended from one of the most distinguished families of South Carolina, the Rhetts. At just what time the family located in the colony I do not know; suffice to say they trace their ancestry back to Colonel William Rhett, who was commander of the land and naval forces under Sir Nathaniel Johnson, Colonial Governor of South Carolina by appointment of Queen Anne, about 1705. The following I read from Harper's Magazine, December, 1882, in an article entitled "Cameos of Colonial Carolina." It relates to noteworthy deeds of this extraordinary man :

Queen Anne having declared war against France and Spain, news was brought the Governor that the French and Spaniards were fitting out a joint expedition against Carolina. The colony was in a poor state of defense. With the fortifications of Charleston in a ruinous condition, the inhabitants depressed from a recent fruitless expedition against the Spaniards of St. Augustine, and "an epidemical distemper" (probably yellow fever) raging in the town and sweeping off numbers of the citizens, the outlook was in the last degree gloomy.

He left Charleston in military charge of Colonel William Rhett, a man whose dauntless courage, regulated by perfect coolness, made him worthy of the post. In due time the tall masts of a French frigate, in company with three ships and a galley, appeared above the low white sand ridge of Morris Island. A courier was immediately sent to Governor Johnson, who the next day, much to the satisfaction of the inhabitants, rode quietly into the town. He forthwith called a council of war, the minutes of which read like some old English burghers' meeting during the reign of Elizabeth; for it was "quickly agreed to put some great guns on board of such ships as were in the harbor, and employ the sailors in their own way in defense of the town."

Of this fleet Colonel Rhett, who, although commanding the militia of the colony, seems to have been quite as good a sailor as soldier, was made "vice-admiral."

At length Sir Nathaniel, measuring with a soldierly eye the fighting qualities of the invaders, determined to take the offensive, and ordered his vice-admiral, Colonel Rhett, with

his six small merchantmen, to bear down upon the Franco-Spanish fleet. Doubtless many a fever-smitten face within the town that day watched the result with dark forebodings. But the affair was soon over. For when the French admiral observed the English ships in motion, he tripped his anchors, and putting immediately to sea, finally disappeared from the coast. A few days after this, Colonel Rhett, still acting as vice-admiral, captured, without firing a gun, a French ship in Seewee Bay, with two hundred men on board, including General Arbuset, commanding the land forces of the invading army. The repulse of this invasion in its results far exceeded the hopes of the colonists. It had been accomplished by skillful maneuvering rather than by hard fighting, and the loss of the English was comparatively small; on the part of the enemy it was very severe. Out of five well-appointed ships and a galley sent against the colony, one ship was taken; out of an invading force of eight hundred men, three hundred were killed or made prisoners. General Arbuset offered as a ransom for himself and his officers ten thousand pieces of eight.

Colonel Rhett, whose gallantry contributed so materially to the defeat of the Franco-Spanish fleet, lived long after the death of Governor Johnson. No man in the province ever held a higher place in the popular regard for coolness and daring. The risk of no enterprise seemed too great for his dauntless spirit. Among the many services, however, which he rendered the colony, there was one that eclipsed all others for desperate bravery — his capture of Stede Bonnet, the famous pirate.

Among the sacramental vessels of the Church of St. Philip, Charleston, may yet be seen a curious heart-shaped paten of beaten silver, and said by those learned in such matters to be of Spanish workmanship. Its history, however, is buried in oblivion. It is possible that it is one of the pieces given by Colonel Rhett. Did he capture it among the treasures of Stede Bonnet? And was it first used in some church or monastery on the Spanish Main?

The worth of Colonel Rhett at length attracted the attention of the home government, and he was appointed Governor of the Bahama Islands; but died before his commission reached him.

Any man might be proud to trace his lineage back to such a progenitor, even if no succeeding ancestors were distinguished; but the Rhetts have ever since held their own in both the field and the forum in South Carolina, one of the most distinguished of the latter being Mr. Barnwell Rhett, who represented his native State in the United States Senate.

Much more might be said touching the history of Dr. Walker's ancestry, but we must hasten on to matters connected with his own personal history and not give more than this passing notice of his forefathers.

Any sort of biographical sketch of Dr. Walker, which would be at all adequate to this occasion, would naturally treat of him in at least three capacities, viz: First, as a student; second, as a physician and teacher; third, as a man.

*Career as a Student.*—As a student we first hear of him at Columbia College, South Carolina, where he distinguished himself by graduating at the age of sixteen years, taking the first honors of his class. He then went to the University of Virginia, where he remained two years, taking the highest rank in every study he pursued. He then began the study of medicine at the University and graduated in one session of nine months, again taking first honors of his class. I have been informed by an alumnus of this institution that the record made by Dr. Walker at the University of Virginia has never been eclipsed by any student who has matriculated there, if it has ever been equaled. No higher compliment could be paid him. I have been told that Aaron Burr's standing at Princeton, his alma mater, stood for generations unapproachable. Dr. Walker's record has stood for more than a generation unequaled in an institution second to none in this country in its standard. From the University Dr. Walker went to New York and stood a competitive examination for Bellevue, when he again passed first in his class. He remained there two years and became chief resident physician.

It will be seen by the above record that the subject of this sketch never

took second position anywhere, he was always first. This closes his career as a student and one more brilliant, I venture to say, cannot be found in the archives of any institution of learning in this country.

*Professional Career.*—He now returned to his native place, Beaufort, South Carolina, where he practiced his profession until the breaking out of the war between the States. Being a true and loyal Southerner he offered his services as a surgeon to the Confederacy. He was examined by the Surgeon-General of the Army, expecting to be made an assistant surgeon. To his great surprise he was made a full surgeon at once, on the excellence of his papers. He had full charge of the South Carolina Hospital at Petersburg, Virginia, and afterwards was in active service in Longstreet's Brigade until the close of the war.

Long before the war closed he had become a most accomplished military surgeon. Not only was he a fine surgeon but a most observant, thoroughly trained and skillful physician. He has often told me of the vast number of autopsies which he made during his military service. Through these autopsies he became convinced of the fact that all cases of continued fevers in this latitude which did not yield in a reasonable time to quinia were typhoid. He has told me that he found disease of Peyer's glands in nearly all fatal cases of continued fever, many of which had been diagnosed as of malarial origin. He was about a quarter of a century ahead of his time. He probably had made during his life as many autopsies as any man in Baltimore and as a gross pathologist he was unexcelled by few if any in this city.

Shortly after he came to Baltimore he was made Chief of the Dispensary Staff of the University Hospital, owned and controlled by the Faculty of Physic, University of Maryland. Some years later he was made Professor of Surgery in the Washington University, the buildings, with alterations and improvements, now belonging to the College of Physicians and Surgeons at the corner of

Calvert and Saratoga Streets. He filled this important chair most acceptably until the institution went out of existence by selling out to the present occupants. The following were some of his colleagues : Drs. J. E. Clagett, William Green, James E. Lindsay, A. B. Arnold, John F. and John N. Monmonier.

For eighteen years he was Examiner in Chief at the Baltimore office of the Equitable Life Assurance Society of New York. He was held in the highest esteem by the officers of this society and especially by its chief medical officer, Dr. Lambert, of New York. Never was confidence more fitly bestowed. He was thoroughly capable, conscientious and firm, no entreaty of the local agents could swerve him one iota from what he believed to be his plain duty. He held this position up to the time of his death.

In 1886 Dr. Walker accepted the chair of Professor of Surgery in the Baltimore Medical College. He at once entered upon his duties with zealous industry and delivered course after course of lectures, every one of which bore the impress of his scholarship as well as that of careful and discriminating research and study. As a teacher he enjoyed the entire confidence and esteem of both the faculty of the institution and the students ; indeed, I may say that he enjoyed their admiration and affection in a high degree. While holding all these important positions, Dr. Walker practiced his profession among a clientèle which if not large was for the most part cultivated and refined people, who were devotedly attached to him.

While Professor of Surgery in the Baltimore Medical College, the surgical work he did in the Maryland General Hospital was immense. He spent hours nearly every day under its roof and got splendid results from all kinds of operations. No doubt his frequent and close attention contributed in no small degree to these ends. Duty was his guiding star in every case he undertook and to fully measure up to the high standard of the *mens concia recti*, he often put his mental and physical powers to the severest test. In his professional intercourse no man held himself to a higher standard

of ethics and no man ever exemplified by such intercourse the traits which properly belong to the true physician, the gentleman and the Christian ; and any failure on his part to get a large and lucrative practice can be appropriately answered in the noble words of Cato, when he said :

*"'Tis not in mortals to command success  
But we'll do no more Sempronious; we'll  
deserve it."*

Dr. Walker, however, was the last to believe that he deserved more than he got. He has often told me that he realized his many deficiencies and had no complaint to make ; he was sure he got his share of deserved success. As a member of this faculty his voice was never silent when the honor and well-being of our institution were at stake. His standard was always high in all matters connected with medical education ; not only so far as the student was concerned, but the faculty as well. He believed that the man who essayed to teach should be well fitted from an educational point of view, for the task, and at the same time should possess qualities of head and heart which would command respect and inspire confidence. Whenever a vacancy occurred in this faculty his vote to fill it was always given to the man whose character and attainments were the highest.

*Third, As a Man.* We have seen from the foregoing that Dr. Walker stood deservedly high as a student, a physician and teacher among those who were fitted to pass judgment on him. I knew him intimately in all those capacities and I do not hesitate to say that he stood even higher as a man. A man, like a tree or plant, is the product of his environment. When the tree or plant is surrounded by every favorable condition for its development, the result is a splendid specimen of the genus. When man is surrounded by every favorable condition to the upbuilding of his mental, moral and physical organization, we look for the finest specimen of the genus homo. The civilization under which Dr. Walker was reared was a remarkable one in many ways. It was essentially the same civilization which

produced Calhoun, at whose bier Webster said : "Here lies the loftiest, purest-minded statesman, patriot and man I have ever known." A South Carolina gentleman held his honor dearer than his life and this sentiment was instilled into his children as soon as they could understand. No less important did they regard truth, courage and honesty ; these were rightly revered as cardinal virtues.

Under the fostering care of a home permeated by exemplary piety, with the strong intellect of his father to guide him in the right way, aided by the love of a good mother, surrounded on all sides by the best and most ennobling influences of South Carolina's highest civilization, we have here the ideal environment for the rearing of a splendid man. Are we to be disappointed ? I answer emphatically, No. Dr. Edmund Rhett Walker was a splendid man. Let us take him as a husband and father, as a host, as a friend, indeed, in any relationship of life, and he will measure up to the highest standard. In his home in the midst of an interesting and loving family, as a husband and father no one could be more unselfish, loving and self-sacrificing than he. He has often spoken to me in the most tender and touching manner about the anxieties he had concerning those dependent on him. He lived for a year or two previous to his death, in dread of — death ? No, in dread of life, linked with helplessness. On such occasions it was evident his great and tender love for his family was ever uppermost in his mind.

He was a devout communicant in the Protestant Episcopal Church and instilled these religious principles, handed down for generations through the family, into all the members of his household. He was in no sense narrow in religion, but charitable and tolerant. He believed that other communions besides his own had good men and women in them. Indeed, he had among his intimate friends several agnostics, and while he deplored their want of faith in Christianity, he valued them most highly as friends. He used to quote the law of Harvey "*omne vivum ex ovo*," or rather

its modification "*omne vivum ex vivo*," i. e., "every living thing comes from a previous living thing," and say this natural law was the bulwark of revealed religion. He thought if life could ever be traced to any other than a divine origin, the agnostic would have substantial ground to stand upon. He held equally as pronounced views on all the questions to which he had given much thought and study as on those of religion.

He believed that the dollar was used in these days, as a unit of measure, where it was altogether inappropriate, harmful and degrading. In politics, in religion and in society he believed it was used to an alarming extent to measure the merit or importance of a man, with nothing but baneful results and general demoralization. He believed firmly in a higher ideal for the nation. He seemed at times to fear for America what Oliver Goldsmith said of England :

"A land to hastening ills a prey  
Where wealth accumulates and men decay."

While he held these views very firmly, he denied nothing to wealth which rightfully belonged to it, but for the individual who was so greedy and selfish and vulgar that he could never rise above the dollar, he had supreme contempt. He believed with Sir Walter Scott :

"Despite these titles power and pelf  
The wretch concentrated all in self  
Living shall forfeit fair renown  
And doubly dying shall go down  
To the vile dust, from whence he sprung  
Unwept, unhonored and unsung."

As a friend he was loyal, generous and warm-hearted. As a host hospitable, unostentatious and gracious. He had, withal, a *bonhomie* which never failed him, and with his friends a play of wit — the kind which amused but did not wound. We have now seen his brilliant career as a student, his distinguished career as a physician, surgeon and teacher, and his exemplary and blameless life as a man. His death, which came with only a few minutes' warning, was a fitting close to such a life. He died like a Christian hero. He said that he knew that the attack meant

death, but said he : " I have no complaint to make against God — remember what I say." He met death without a tremor. " Oh, death ! where is thy sting ? Oh grave ! where is thy victory ? "

Before closing this imperfect sketch, I wish to say that after a close intimacy with him for fifteen years, I believe Dr. Walker, with but one exception, was the purest and most unselfish man I ever knew. One of England's greatest statesmen once pronounced upon Washington the most just, and at the same time the most epigrammatic, eulogium that I have ever heard. He said : " Washington was the greatest of good men and the best of great men." If you will permit

me to alter and paraphrase this somewhat liberally it will in my opinion be appropriate to Dr. Walker. He was the best of good men. He measured up to Cardinal Wolsey's injunction : " Still in the right hand carry gentle peace to silence envious tongues. Be just and fear not ; let all the ends thou aimest at be thy country's, thy God's and truth's."

And now, in the name of the faculty of the Baltimore Medical College, do I dedicate this mural tablet of brass to the memory of Dr. Edmund Rhett Walker, as an enduring evidence of their admiration and esteem. Through the years to come, may it stand a silent yet eloquent monitor, to each of us, pointing to the path which leads to duty and to honor.

## THE MENTAL DISTURBANCES OF THE CLIMACTERIC PERIOD.

READ BEFORE THE TRI-STATE MEDICAL SOCIETY AT CUMBERLAND, MD.,  
DECEMBER 12, 1895.

By George H. Rohé, M. D.,

Superintendent of the Maryland Hospital for the Insane; Professor of Therapeutics, Hygiene and Mental Diseases in the College of Physicians and Surgeons, Baltimore.

THE "change of life" in women is usually attended by many symptoms, among the more characteristic of which are irregularity, followed by cessation of the menses, abolition of the function of ovulation and decline of the sexual desire.

Waves of heat, commonly called "flushes," are nearly constant. These flushes are often accompanied by free sweating, which may be general or localized. Headaches, more or less intense, are frequent. Leucorrhea and pruritus vulvae are not rarely troublesome. Precordial pain or anxiety, tachycardia and irregularity of the pulse, are present at times.

Most of these manifestations are, however, well known, are generally looked upon as inevitable, and are borne with more or less equanimity by the patients.

A form of glycosuria occurs at the period of the menopause, usually in fleshy persons. Its prognosis is rather favorable. Hysterical attacks are liable to be more frequent as well as more ag-

gravated during this period in predisposed individuals.

Among the more serious accompaniments of the menopause is mental disorder. Statistics show that insanity in women is especially frequent between the ages of 40 and 50 years. As this is also the ordinary period of cessation of the menses, the conclusion seems reasonable that some relation exists between the two conditions, although it must not be assumed that mental disturbances at this period are necessary consequences of changes in the functional activity of the sexual organs.

Any of the clinical varieties of mental disorder may be present during the climacteric ; but melancholia is most frequent. In 22 cases studied by Goodall and Craig, melancholia was present in 66 per cent. In 21 cases under my own observation, exactly the same proportion were of depressive forms at the time they came under notice. Dr. Bevan Lewis states that at the early evolution of climacteric insanity, pain-

ful mental states invariably prevail, and in the large majority of cases mental depression exists throughout the attack.

Hallucinations of hearing and of smell are frequent. Religious delusions color most cases. The class of cases termed by Savage "Unpardonable Sinners" are especially frequent among women who become insane during the climacteric. Dr. Bevan Lewis refers to these cases in the following terms: "Delusional states were recognized in 73 per cent., and out of a total of sixty-one deluded cases, sixteen were victims to the terrible delusion that the soul was eternally lost, and that the subject was to be consigned to the flames of hell." It is strange to witness the prevalence of this religious despondency at a period when, as we are aware, the generative organs are undergoing an important cyclical transformation, and to contrast it with the converse states of religious exaltation so frequently associated with the sexual transformation and excitation of adolescence, of hysterical and epileptic forms of insanity."

The fear of death, immediately impending, or more or less remote, is often present. In two of my cases, this was the almost constant theme of lamentation. Frequently the memory and judgment are but little impaired, but the patients complain loudly of confusion of thought, fear they will become insane, will never recover, etc.

One of my cases is constantly worrying about the confusion in her head. She says she cannot understand what she reads in the papers, although she discusses current events with much perspicacity. She has always been acute in business transactions, and her family will not admit that she has lost any of her accustomed shrewdness. In spite of this, however, she insists that she has lost all the business ability she ever possessed. According to her own account, her vision and hearing are confused, the sense of taste lost and even the sphincter reflex absent. But she never soils herself, the sense of fulness in the rectum preceding defecation always recalling her to the proprieties of the occasion. Of late she has had at

times an uncontrollable desire for alcohol, and when seized with this, will go to any extremes to get a supply. She states that in the early period of her married life her sexual desire had been so great that she practiced masturbation and attributes all her physical and mental ills to that vice. This notion is so firmly fixed that it partakes of the nature of a delusion out of which she cannot be reasoned.

Another case is a white woman of Hebrew race, 42 years of age. She had always been of a nervous disposition and subject to periods of depression of spirits which, however, never before reached the intensity of melancholia. Her menses ceased two years ago, and about six months later she had spells of depression alternating with her normal condition. The normal intervals gradually decreased, and finally the depression became constant. She lost interest in her home, family and church duties; frequently wept; refused to talk to or even see her friends. She was often restless and agitated and would walk about her room for hours at a time.

She was admitted to the hospital in November, 1894. Until recently, she was almost constantly depressed, weeping, complaining of a confused "worrying" feeling in her head, feared she would never recover, suspected her husband of infidelity, feared she would lose her mind. Also had the delusion that her conduct toward her relations was a great crime and could never be forgiven; in short, she was one of the victims of the unpardonable sin. Her physical condition, which was bad, was still further depressed by cancer of the breast, which was discovered on her admission. An operation for the removal of this was proposed, but was declined by the relatives until decided involvement of the axillary glands had taken place. The consent of the relatives to the extirpation was finally given and in May last, Halsted's operation was done. At present there is no evidence of return of the morbid growth.

All the usual remedies for her mental condition — opium, strychnine, etc.— were tried without noticeable ameliora-

tion. Nuclein solution, protonuclein, and hypodermic injections of sodium phosphate were tried without result. Finally, about two weeks ago, she was put upon thyroid extract, with almost immediately favorable effect. She has become cheerful, quiet, does not complain of the confusion in her head and is hopeful of her recovery; a hope which is at present shared by the medical staff of the hospital. (Since the above was written, this patient has recovered, and been discharged.)

Delusions and hallucinations referable to the sexual sphere are common. Most cases of pseudo-cyesis occur during the climacteric. I have recently had a case of this absurd delusion under observation. Fear of grave disease of the pelvic organs is often present. The subjective sensations of itching and burning in the external organs and the presence of leucorrhea are probably the causes of this morbid fear. Actual disease of the sexual organs is, however, often present, and all cases should be thoroughly examined to determine this point. The great frequency of uterine cancer at this period of life must not be overlooked.

Delusions referred to the digestive organs are also present, although not characteristic. One of my cases insisted that her internal organs were all decayed, and that therefore it was useless to give her food or medicine. If she had a stomach, she might possibly recover, but as this organ had been entirely destroyed there was no possibility of ever getting well. Another case recently admitted insists that her entrails have been taken out and thrown to the chickens. She also has a delusion that the staff are not doctors, but are butchers who are trying to fatten her in order to kill her. On her admission she refused food, but after several days' forcible feeding she began to eat and improved rapidly in her physical condition. Her delusions are also somewhat less prominent. (This patient has recovered and has been discharged.)

Delusions of grandeur are sometimes present in the maniacal and paranoiac cases.

Suicidal tendencies are frequent, al-

though usually not so persistent as in melancholia generally. In one of my cases, however, the patient set fire to her clothing "to escape from the devil," and was so severely burned as to result in death. Lewis refers to a case in which an attempt at self-destruction was made to escape a similar alleged danger. The apprehension of death by fire is frequent.

In some cases the depression and mental anxiety lead to the use of alcoholic stimulants, resulting often in confirmed intemperance.

While there is no specific form of mental disorder that can be properly termed "climacteric insanity" there can be no doubt that the menopause must be considered as one of the exciting causes of mental disease. Some writers devote much attention to the consideration of a climacteric insanity in the male sex, but there is no period in the life of men that corresponds with the menopause in women. The parallel that has been drawn between the period of involution of the sexual power in man and the climacteric period in women is, as Dr. Bevan Lewis says, "more fanciful than strictly correct."

The prognosis of the insanities of the menopause is, according to authors, rather favorable. In my own cases, including even those who had already passed into dementia when they came under observation, the recovery rate is 43 per cent. Goodall and Craig had 38 per cent. of recoveries; Sutherland a fraction over 40 per cent.; Lewis 48 per cent.; Merson nearly 50 per cent.; Skae 53.5 per cent. and Clouston 57 per cent.

Death is rare as an immediate consequence of the psychical derangement. Suicide and marasmus in those cases refusing food form the largest contingent of deaths in the acute condition. Among the chronic cases, tuberculosis claims the largest share in the death rate.

I have elsewhere expressed the opinion that a considerable proportion of cases of insanity following extirpation of the ovaries are simply cases of climacteric insanity. (An Inquiry into the Etiology of Mental Disturbances following operations upon the Female Pelvic Or-

gans, *New York Medical Journal*, October 14, 1893.) Further observation has added support to this view. Two of the cases in the series upon which this paper is based followed removal of the ovaries. In one of these, an intelligent mulatto woman upon whom I operated in 1890, the usual symptoms of the menopause, flushes, nervousness, palpitation of the heart, were very marked. After a few months decided mental depression developed. The patient was dominated by the fear that she would become insane. She even expressed a desire to enter an insane hospital so that she might have proper treatment. Under tonic treatment, with opium, these symptoms gradually passed away, and the patient ultimately entirely recovered. The second case had been operated upon in 1889 by a Baltimore gynecologist. Four months afterward an attack of melancholia supervened. She suffered from sleeplessness, was greatly depressed and had the delusion that she had committed some great sin. She was admitted into the Maryland Hospital and under the treatment of my predecessor, the late Dr. Richard Gundry, she recovered in about six months. After her discharge she returned to her occupation, that of a milliner, and for some time continued well. She gradually became addicted to alcohol, however, and in April, 1895, was re-admitted, suffering from agitated melancholia, with great physical depression. Since her second term of residence in the hospital she has had an apoplectic attack, from the physical effects of which she has recovered. The mental depression has somewhat improved, but I fear she is passing into a state of dementia.

The treatment of the mental disturbances of the menopause often tests severely the patience as well as the therapeutic resources of the practitioner. Refusal of food often depends upon delusions, but at times disorders of the *primae viae* are responsible. In the latter case stomach washings, laxatives and intestinal tonics such as nux vomica and physostigma are indicated. Where the reluctance to take food or its absolute refusal depends upon delusions

that the food is poisoned or that the viscera are decayed, forcible feeding must generally be resorted to. In cases of aggravated gastric catarrh the subcutaneous infusion of a nutritive saline solution, as practiced in the Maryland Hospital for several years past, will often be beneficial. After a few days' rest the stomach will take up its functions with renewed vigor.

The precordial anxiety and palpitation of the heart, if troublesome, will generally yield to moderate doses of Hoffman's anodyne. For insomnia, paraldehyde is probably the least harmful hypnotic that can be used, although where its odor and taste are objectionable and there is no cardiac weakness, trional may be substituted.

The physical depression needs good food, fresh air and tonic medication. In states of great weakness, absolute confinement to the bed is necessary to prevent exhaustion.

Symptoms referable to the sexual organs are not always evidence of delusion, and should not be so declared until a careful physical examination has shown the absence of local disease.

Mental depression is best combated by cheerful surroundings, out-door life, and medicinally by opium. This drug should be given systematically, beginning with small doses and gradually increasing until the depression is overcome; or until it is found that no good can be obtained with it. I have frequently carried the daily dose to 6 or 8 grains without ill effects. When the depression yields to a more cheerful state the dose is gradually diminished to the vanishing point. Cannabis indica and belladonna are also at times useful. I have not used cocaine or any preparations of coca for fear of inducing the cocaine habit.

The good effects of thyroid extract in one of my cases, and the favorable reports from the use of this remedy, by others, especially in melancholia, encourages to further trial with it.

The depressive hypnotics and sedatives such as chloral, bromides, sulphonal, antipyrine, etc., should generally be avoided in depressive mental states.

## A CASE OF POISONING.

By E. T. Duke, M. D.,  
Cumberland, Md.

A RATHER unusual case of poisoning occurred in my practice some time ago which I think worth reporting.

A married lady, aged 38 years, accidentally, it was thought, swallowed about half an ounce of a liniment composed of aqua ammonia, tincture of opium, tincture of aconite and alcohol.

When I saw her an hour after the accident profoundly under the influence of the opium, with no symptom of aconite poisoning, she was stupid and semi-conscious but could be roused by the use of force, and replied at random to some questions asked her. After the liniment had first been swallowed she took some water with thin pieces of ice in it, and at this time complained of difficulty of swallowing and pain in the throat due, no doubt, to the ammonia.

The greatest difficulty was experienced in efforts to induce emesis but persistent use of apomorphia hypodermically and mustard internally finally caused free vomiting. Although a half drachm of tincture of aconite had been swallowed the effects of the opium were most pronounced. The pupils were contracted until hardly perceptible, and the quieting effect of the opium on the stomach was shown by the difficulty experienced in causing vomiting. The ammonia and alcohol acting as antagonists to the poisonous effect of the aconite

prevented it doing harm, and the opium alone had to be dealt with.

The depressant effect of the aconite was not at all marked and the patient did not complain of the feeling of tingling or numbness usually experienced after full doses of aconite. Appreciating the advantages of quiet and the recumbent position in aconite poisoning, and the risk of allowing the patient to sleep in opium poisoning, I was somewhat at a loss to know what was best to be done. Thinking a middle course best the patient was allowed to sit in a chair, and was carefully watched.

After she had vomited the contents of the stomach, improvement was noticed in her condition and within six or eight hours she had regained entire consciousness, and was none the worse for her experience, with the exception of an inflamed throat.

In addition to the interest this case had for me as showing the antagonistic action of the drugs named, a lesson of importance might be learned. A bottle similar to the one containing the liniment had cough syrup in it, hence the mistake.

I would advocate the use for all external remedies of a special bottle, of dark glass and corrugated edges, which would lessen mistakes, which are often both serious and fatal.

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MALARIA.—Dr. John Lovett Morse studied twenty-six cases of malaria at the Boston City Hospital. Diagnosis was made by the blood and treatment was based on this. Quinine was given shortly before the paroxysm and a second dose before the next paroxysm. He continues the quinine for ten days or two weeks after the time the paroxysms appeared, even though they had apparently ceased. He has given fifteen or twenty grains for the first dose and ten

grains for the second. He records his observations in the *Boston Medical and Surgical Journal*. All his cases recovered.

\* \* \*

ORGANIC EXTRACTS.—Dr. Frederic Coggeshall of Boston gives, in the *Boston Medical and Surgical Journal*, the results of a series of experiments from which he concludes that "these so-called organic extracts are physiologically inert and therapeutically worthless."

## Medical Progress.

RE-ENGRAFTING OF LOST SKIN.—To Dr. Zera J. Lusk of Warsaw, N. Y., says *The Sanitary Era*, seems to belong the credit of an important discovery for the facilitation of skin-grafting, especially in case of extensive scalds. It is the practicability of reclothing the flesh of the victim with the same skin that had been stripped off by scalding. The success of this experiment in an extreme case led to the trial of the skin of a blister with equal success in another case; a method for obtaining grafts from the patient or friends with much less pain and subsequent inconvenience than by the knife.

Dr. Lusk's report of his extraordinary case and novel procedure, read before the New York State Medical Association October 17, 1895, is reprinted in the *New York Medical Record*. The patient had fallen head foremost into a pan of boiling brine at the Hawley salt works, and while comrades had nearly dragged him out, their hold slipped and he fell backward into the brine again; thus becoming scalded before and behind, over more than two-thirds of his entire surface. "Great bags filled with serum hung from his sides and other parts of the body. Both arms were completely stripped of epithelium, which hung in shreds about the wrists, having been scraped down in his effrots to get out of the pan. The thick calloused skin of the palmar surface of both hands was torn and in shreds. The dorsal surfaces were covered with sacks full of serum. There was a raw, bleeding surface six inches wide extending from the left arm to the middle of the right scapula; one of the same character and size covered the lumbar region. The buttocks were covered with large blisters, but more superficially. The skin on the lower extremities hung in shreds, bleeding in many places, especially about the knee and ankle joints. The genitalia were very edematous, and covered with bullae. There were numerous small vesicles on the face and neck, and large erythematous patches over the chest and abdomen, but no vesication except in the right in-

fra-clavicular region, where there was a blister four inches in diameter. It is unnecessary to state that there was profound constitutional disturbance, and that no hopes of his recovery were entertained."

Nevertheless, the almost unparalleled vitality of the sufferer triumphed, and after four weeks of singular survival in an apparently hopeless condition, favorable symptoms supervened and encouraged an effort to repair the injury. To make a long story short, after trying such insufficient expedients as were at hand, as a last resort Dr. Lusk thought of the ample patches of dead and dried cuticle that still hung by their edges to the denuded and in some parts gangrenous and sloughing flesh. Taking a piece of this crisp parchment, he softened and sterilized it in warm boric-acid water, and dividing it into small grafts, applied them to a granulating surface, with an "eminently satisfactory result." "Seven of the twelve grafts took and rapidly developed into vigorous islands of skin." The work so well begun was carried on in the same way, and in seven weeks (April 1, 1895) was completed; the patient began sitting up; and in one month more resumed light labor at the salt works. There was no cicatricial contraction, and the free use of the joints and muscles was unimpaired.

From this experience, as already stated, arose the suggestion of obtaining cuticle for the cure of a chronic varicose ulcer, by means of a cantharides blister on a sufficient surface of the patient's thigh "(it being first moistened with carbolized oil). Vesication was produced in six hours when the plaster was carefully removed. The epithelium was detached at the edges of the blister, washed in boric acid solution, after which all moisture was absorbed with sterilized cotton, and it was suspended in a bottle (aseptic cotton being used for a stopper), and kept at a temperature between 55 and 70 degrees Fah. It was thoroughly dry in three days, when a piece one inch square was divided, making twelve grafts, which were applied in the usual way. The re-

sults were extremely gratifying. Nine of the twelve grafts took nicely and grew rapidly, so that by September 3 the ulcerated surface was healed, having a substantial epithelial covering."

Excellent patients like these, of course, can reward the skin-grafting surgeon, if competent, with brilliant successes. But in cases not so robust or healthy in blood, it would be malpractice in the present state of knowledge to risk the omission of topically supplied blood in the daily dressing; while in all cases, the best success of the surgeon, the permanence of the repair, and what is also notable, the comfort of the patient, in freedom from pain, can be fully secured only by the magical power of "Nature's sweet restorer," vital blood.

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**HEART DISEASE IN CHILDREN.**—Pott (*British Medical Journal*) discusses the etiology of heart disease in childhood. Among 30,000 children he found 95 cases of heart disease, upon which he bases his conclusions. Acquired heart disease is, in his experience, never primary, but always secondary to some acute infectious disease, particularly scarlet fever and acute rheumatism, occasionally to pneumonia. In early childhood the rarity of scarlet fever diminishes its importance in the causation of heart disease. The youngest case observed was a boy, aged 3, in whom endocarditis developed in the second week of scarlet fever, leaving permanent mitral regurgitation. Rheumatic fever is the commonest cause in these earlier years, and the statements of other writers who assert the infrequency of rheumatic fever at this age are probably due to the difficulty of diagnosis causing it to be overlooked. Of 78 cases of acute rheumatism with joint symptoms, 21 were under the age of 2 years. A frequent cause of heart disease in children is the so-called masked rheumatism, a vague febrile condition associated with naso-pharyngeal catarrh, enlarged cervical glands, enlarged spleen, herpes labialis, and pains in the limbs, sometimes called herpetic fever. These symptoms subside under sod. salicyl., and have

sometimes been definitely associated with the onset of endocarditis and pericarditis. Owing, however, to the difficulty of proving their rheumatic origin, the writer has not included such among his rheumatic cases. Congenital heart disease, not including faults of development, may be due in some cases to an attack of acute rheumatism in the mother during pregnancy; one case is quoted in which there seemed to be such a relation. Congenital syphilis in three cases seemed to be the probable cause of the heart lesion. The frequency of acute miliary tuberculosis in children with congenital right side lesions is noted, and the possibility of intra-uterine tuberculosis as the cause of the heart disease is suggested, though it seems more likely that the tuberculosis is favored by the heart disease.

\* \* \*

**RULES FOR MONTHLY NURSES.**—Dr. G. E. Herman (*British Medical Journal*) gives the following rules for monthly nurses:

1. The nurse, while she is in attendance on the patient, should wear a clean, light-colored cotton dress and clean white apron. She should turn up her sleeves when about to do anything that might soil them. She should not wear fancy rings or sleeve links. She should keep her nails short.

2. She should see that the following things are ready in the room in which the patient is to be delivered: (1) Materials for making a solution of corrosive sublimate; (2) a 2-oz. wide-mouthed bottle containing a solution of corrosive sublimate in glycerine, 1 in 2000 (these things to be got from the doctor or by his prescription); (3) a douche tin with 6 feet of india-rubber tubing, stopcock, and vaginal nozzle; (4) a nailbrush.

3. She should make in a basin, or in a jug with a mouth wide enough to admit the hand, a quart of 1 in 1000 solution of corrosive sublimate, and place it on a table by the side of the bed.

4. Before touching the patient she should (1) well wash her hands, nails and wrists with soap and water and a nailbrush; (2) after rinsing off the soap

she should hold her hands in the sublimate solution, and rub them together for a full minute.

5. After labor she should wash the external parts with a solution of corrosive sublimate 1 in 2000, using clean wool, not a sponge.

*Need for Discipline.*—It is useless for the doctor, by precept and example, to instruct the nurse about antiseptics if she thinks that she may follow his instructions or ignore them as her convenience or fancy, or that of the patient, may dictate. The doctor should so explain to the patient the importance of antiseptics, and the reasons for the instructions he has given to the nurse, that she may see that they are not arbitrary or capricious, but necessary. Then he can ask her to engage her nurse on the distinct understanding that she is to obey the antiseptic rules laid down by the doctor, and that neglect to do so will not be looked on as a trifle, but will be followed by dismissal, however excellent in other ways the nurse may be.

\* \* \*

**OVER-PRESSURE IN SCHOOLS.**—Complaints of over-pressure in schools have been made for a long time past (*Lancet*) and the development of hygiene, together with the increasing interest of the public in sanitary matters has rendered parents more and more nervous. In Germany many subjects are included in the school training which in other countries are taught in the universities; the number of daily lessons is, therefore, usually very great, and the weaker pupils often suffer from the over-exertion. In the *Deutsche Medicinische Wochenschrift* Professor Eulenburg criticises the time-table of a well-known Berlin "gymnasium," where the sixth class has thirty-three lessons weekly. On one day the pupils have six consecutive hours of study with only two intervals of ten and fifteen minutes respectively; there are also afternoon lessons on two days, and the pupils have to go to school twice a day. Dr. Herter of Frankfort complains of similar evils at a "gymnasium" of that town. Dr. Eulenburg points out that according to

the researches of Griesbach the brain of an over-exerted child requires several hours of rest till it regains its normal faculties, and Burgerstein has stated that boys of twelve years of age require, as a rule, an interval of several minutes after forty minutes devoted to study; but the opinions of these eminent men seem to have little weight with the school authorities. Both the medical profession and the public have on several occasions asked for the establishment of medical supervision in connection with the schools, but the school authorities, actuated by *esprit de corps*, have always been opposed to the interference of medical men in what they believe to be their own domain. The facts and opinions above enumerated, however, prove that the coöperation of medical men and school teachers is sometimes very essential.

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**THE NAUHEIM TREATMENT OF HEART DISEASE.**—Dr. Robert Saundby gives a very interesting account in the *British Medical Journal* of a visit to Dr. Schott's Institute, at Nauheim, near Frankfort and Homburg. The method is by the use of mineral water externally and internally and by certain forms of gymnastics. The system is claimed by Dr. Schott to be of special value in all cases of chronic heart disease except where there is advanced degeneration of the myocardium, or aneurism of the heart or great vessels, or advanced arterio-sclerosis. It has proved of great service in all forms of valvular disease, in congenital cardiac defects, in simple dilated hearts without valvular disease, in the functional cardiac debility of anemia, however induced, in nervous, irritable hearts, in simple tachycardia, and in the rapid heart of Graves' disease. In addition to the use of the water and certain gymnastic exercises, mountain climbing is ordered, especially for the younger patients. By repeated examinations the slowing of the pulse and a decrease in the cardiac area were observed and in many cases there was marked improvement after a short treatment.

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BALTIMORE, JANUARY 25, 1896.

THE MARYLAND MEDICAL JOURNAL is regularly in receipt of the *Journal of Orificial Surgery*, which is published by several homeopathic physicians in Chicago. By reference to the advertisement of the Chicago Homeopathic Medical College, one of the editors is seen to be Professor of Orificial Surgery, and another Lecturer on Orificial Surgery, and the other subscribes himself as a general practitioner and orificial surgeon.

The specialty of orificial surgery is not recognized by the regular medical profession, or at least not under this title, though it appears to occupy a prominent position amongst the homeopaths. The term orificial surgery naturally has reference to the surgical maladies occurring at the various orifices of the body, but from a perusal of the transactions of the eighth annual session of the American Association of Orificial Surgeons, there is room for doubt as to the scope of orificial surgery,

and as to the functions of the orificial surgeon.

As might be expected, rectal surgery claimed much of the attention of the convention, and gynecology came in for a full share of consideration, but many other subjects likewise were discussed by the "orificial surgeons" present, such as the relation of the sexes, married and otherwise, sexual perversion, and the instruction of children in regard to "where little babies come from." One "orificial surgeon," a lady, explained how she had taken a week's vacation in the country, in order to talk with her two children, nine and seven years of age, "as to where the little ones came from." Another bluff surgeon related how he had talked to his boy, who was ten or eleven years of age, about these matters, but found that the boy "knew more about it than I did, and then I thought I would let the young one take care of himself."

Leaving this interesting subject, it is found that these orificial specialists are engaged with weighty anatomical and physiological problems, such as the functions of the solar plexus. One orificial physiologist finds that it is "the seat of the emotions and affections." "If you feel sorrow, it is there; if you rejoice, it is there also—it is not in the mind, the mind is simply a reasoning organ." Whilst it is admitted that many people have a great affection for their gastronomic centers, science does not teach that this plexus is actually the seat of joy, nor that sorrows reside in those mysterious regions, except when certain qualms of conscience resulted from a too liberal indulgence in watermelons, cucumbers or clams.

Orificial surgery has a very wide field of usefulness, in the cure of locomotor ataxia, gall stones, cancer of the uterus, enlargement of the prostate, piles, etc., but the most remarkable application of the art is recorded in a short paper entitled, "The Dead Resurrected by Anal Dilatation." Some years ago a prominent physician of this city, whilst spending his vacation at the seashore, met a female homeopathic doctor, who immediately began to descant upon the great superiority of her system of practice over the "allopathic" method. The Baltimore practitioner congratulated the homeopathic sister upon her improved and satisfactory method, and acknowledged that, in spite of all his efforts,

his patients would die. It is probable that the lady doctor was an orificial surgeon and it is possible that she employed anal dilatation to resurrect the dead, or at least to snatch her patient from the very jaws of death.

To return to the marvelous case recorded, a California "orificial surgeon," in an ecstasy of admiration, exclaims, "I am proud to report that the knowledge of orificial surgery has given a human being a chance to gladden a mother's heart, and perhaps grow up to be a useful woman." The facts in the case are as follows: After a tedious labor, the child is delivered with forceps and in an asphyxiated condition. The physician, after cleaning the mouth, throat and nostrils of secretions, dilated the sphincter ani, and then performed artificial respiration. At the expiration of thirty minutes he was rewarded by seeing the child draw its first breath, and an hour later its color was normal and resuscitation was complete.

Time and space are wanting in which to note many other orificial facts learned from the journal in question; there may, however, be mentioned a few homeopathic and "orificial" remedies employed in the after-treatment of various "orificial" operations. Morphia sulphate grains  $\frac{1}{4}$  hypodermically to relieve pain. Compound liquorice powder, Garfield tea, cascara, and salts for cathartics.

Many other remedies are suggested and all are catalogued in the specialty of orificial surgery. Truly this is an age of advancement and there is much to be learned.

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SENN, in a recent work on tumors, says that there is no doubt in his mind that the advantages of the microscope

*The Microscope in Surgery.* as an aid in the diagnosis of tumors have been greatly overestimated. This is a very important statement, and he cites the case of the late Emperor Frederick of Germany as an example.

Enthusiastic microscopists did at one time feel as if the character of all tumors could be at once settled by the use of the microscope, but experience has shown that the macroscopic appearance of the tumor, its site, character of growth, etc., must all enter in to make a complete diagnosis, and when a piece of tumor is sent to a microscopist for exami-

nation, it should not be sent as a puzzle, but a history of the case with all other points should be submitted and as large a piece of the tumor sent in as is possible.

It is extremely difficult to make a diagnosis from scrapings of tissue and when the surgeon sends the pathologist a piece of tissue for examination he does not take that step in order to see how much the pathologist knows or what the microscope alone will reveal, but he wishes the pathologist's aid in making a diagnosis and the two should work in harmony. The microscope usually decides when the naked eye appearances throw a doubt on the character of the tumor.

\* \* \*

IT is extremely difficult for hobby-riders to be temperate. An exchange brings up the

question of clergymen  
*Clergymen and Tobacco.* and tobacco, and maintains that ministers of the gospel should not only refrain from the use of tobacco, but should preach against it, and then proceeds to quote a series of cases of the *post-hoc-ergo-propter-hoc* variety showing the direful results of the use of tobacco.

If persons would discriminate between the use and abuse of any one thing their words would be of more effect. Tobacco has certainly done a great deal of harm, as has water when improperly applied. The growing youth should be hindered when possible from indulging in tobacco in any form, not altogether because it harms boys at a tender age, but because such boys have no judgment and use more than they should.

A grown man smokes a cigar in the evening or at the end of each meal and he feels better and brighter for it; he can think better; it soothes him and by putting him in a better frame of mind certainly aids digestion. In most homes for old men rations of tobacco are allowed. The sailor is allowed his tobacco. The government recognizes these needs.

There are few men who enjoy a good quiet smoke more than a clergyman. Some may consider this a bad example and it might look out of place, especially in a small town, for a well known minister to be seen walking the principal streets smoking a cigar or pipe. Some denominations make it a prerequisite that the clergyman shall promise not to use tobacco while in that charge.

## Medical Items.

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We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending January 18, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....	.	.
Pneumonia.....		32
Phthisis Pulmonalis.....		31
Measles.....	89	3
Whooping Cough.....	17	3
Pseudo-membranous {		
Croup and Diphtheria. }	14	8
Mumps.....	3	
Scarlet fever.....	8	
Varioloid.....		
Varicella.....		
Typhoid fever.....	8	4

The New York Post-Graduate Medical School has a Chair of Climatology with Dr. Leonard Weber as professor.

Mrs. Anna R. Aspinwall of Pittsburg has bequeathed \$3,000,000 to the Episcopal Hospital of Philadelphia.

The death of Dr. Charles Fauvel of Paris, the well known laryngologist, is announced as having taken place on December 17.

The Berlin Medical Society has subscribed a thousand francs toward the monument to Pasteur, which is to be erected at Dôle, his native town.

The Harvard Medical School requires a degree for admission. In this step Harvard has followed the example of the Johns Hopkins University.

Miss Helen Culver has given \$1,000,000, and Mr. John D. Rockefeller has promised \$2,000,000, to Chicago University, which will probably be used to found a medical school.

Dr. E. L. Godfrey of Camden has been elected Secretary of the State Board of Medical Examiners of New Jersey, in place of Dr. William Perry Watson of Jersey City, resigned.

The Presbyterian Eye, Ear and Throat Charity Hospital has issued the first number of an attractive bulletin containing reports of work with scientific articles by members of the staff.

The Craig Colony for epileptics was opened at Mount Morris, New York, last Monday. Thirty will be received at once. Applications have come in from all parts of the country.

Ex-Governor Brown's place, Springfield, near Sykesville, Carroll County, has been bought for the new insane asylum. It contains a large manor house, small tenement houses and 728 acres of ground.

A system of athletic exercises is to be introduced in the Police Department of Chicago, for the purpose of developing skill and agility and endurance among the patrolmen. Such a system has long been in use in Baltimore.

Mayor Quincy has appointed as a board of experts to examine into the sanitation and ventilation of the public schools of Boston, Professors Francis W. Chandler and S. H. Woodbridge of the Institute of Technology, and Mr. Frederic Tudor.

At the last meeting of the Gynecological and Obstetrical Society of Baltimore, held January 14, 1896, Dr. Robert T. Wilson was elected first Vice-President to fill the vacancy caused by the death of Dr. J. Edwin Michael. Dr. Wilson has been treasurer of the society since its foundation in 1885, and has filled this office most efficiently.

At the annual meeting of the Richmond Academy of Medicine and Surgery held in December, the following officers were elected for the ensuing year: President, Dr. Landon B. Edwards; First Vice-President, Dr. John N. Upshur; Second Vice-President, Dr. J. P. Massie; Third Vice-President, Dr. J. W. Henson; Secretary, Dr. Mark W. Peyser; Assistant Secretary, Dr. W. F. Beazley; Treasurer, Dr. J. F. Woodward; Librarian, Dr. R. A. Nichols.

Cincinnati has a new building for physicians. A number of physicians and dentists have taken offices there. On one floor is a dispensing druggist, and in the basement there are being fitted up elaborate medicated baths which will be opened to the public on a physician's prescription only. In addition to this, the building is to have many special features to fit it for use as doctors' offices, such as electric light, electric elevator, hot and cold water, steam heat, private telephone lines, a laboratory, library and operating room for the tenants.

## WASHINGTON NOTES.

We are indebted to the Health Department for the following: "The death rate for the District of Columbia took a sudden upward turn last week. The deaths reported numbered 146, as against 78 by the last report, of which 20 were from affections of the lungs. There were 27 fatal cases of pneumonia and 22 died of consumption. There is but slight presence of contagious maladies in the city, there having been but one death from diphtheria. Nearly one-fourth of all the deaths were from diseases of the brain, heart and kidneys, 13 of which were from the latter. Four deaths from typhoid fever were reported and 2 from grippe. Infant mortality ran up to 37. The hospitals reported 23 deaths during the week and the Coroner certified to 14 deaths. There were 112 births during the week."

The regular meeting of the Medical Society of the District of Columbia was held on Wednesday evening, January 15, the President, Dr. Samuel C. Busey, in the chair. Dr. Wm. B. French read a paper entitled, "The Malarial Organism, with Report of Cases." Dr. Wm. Gray showed by means of the magic lantern some photomicrographs. Drs. Walter Reed of the Army Medical Museum, Kinyoun and others joined in the discussion. Dr. J. Ford Thompson presented case and specimen of Extra-Uterine Pregnancy.

The Washington Obstetrical and Gynecological Society met on Friday evening, January 17, the President, Dr. George Byrd Harrison, in the chair. Dr. Thomas C. Smith presented a specimen, which was referred to the Microscopical Society for diagnosis. It was thought by Dr. H. L. E. Johnson a form of hollow polypus. Dr. Henry D. Fry reported a case of supra-pubic hysterectomy for a perforated uterus following an abortion, followed by suppression of urine. Dr. Joseph Taber Johnson presented specimen of hysterectomy for cancer and Dr. John Van Rensselaer presented a specimen of appendicitis with ulceration. Dr. H. L. E. Johnson presented specimen of small ovarian cyst and also reported a case of tubercular peritonitis and laparotomy. Dr. Kelley's paper on Fibroids of the Uterus, Complicating Pregnancy, read at the previous meeting, was discussed at great length by Drs. Henry D. Fry, J. Wesley Bovée, A. L. Stavely, I. S. Stone, T. E.

McArdle and Joseph Taber Johnson. Dr. J. W. Bovée's paper on Anterior Colpotomy had to be postponed until another meeting on account of the lateness of the hour. The Society then adjourned.

## Book Reviews.

SYSTEM OF SURGERY. Edited by Frederic S. Dennis, M. D., Professor of the Principles and Practice of Surgery, Bellevue Hospital Medical College; Visiting Surgeon to the Bellevue and St. Vincent Hospitals; Consulting Surgeon to the Harlem Hospital and the Montefiore Home, New York; Ex-President of the American Surgical Association; Graduate of the Royal College of Surgeons, London; Member of the German Congress of Surgeons, Berlin; assisted by John S. Billings, M. D., LL. D., Edin. and Harv.; D. C. L. Oxon.; Deputy Surgeon-General, U. S. A. Vol. III. Surgery of the Larynx, Tongue, Jaws, Teeth, Salivary Glands, Neck and Chest.—Diseases and Surgery of the Eye and Ear.—Surgical Diseases of the Skin.—Surgery of the Genito-Urinary System.—Syphilis. Profusely Illustrated. Philadelphia: Lea Brothers & Co. 1895.

The third volume of this splendid system of surgery merits as favorable notice as the preceding volumes. This volume is, however, of rather less interest to the general surgeon and practitioner than the others, as it treats largely of special affections, which usually go to the specialist in the various branches. Dr. D. Bryson Delavan of New York contributes the section on the surgery of the larynx, trachea, nose, tonsils and pharynx, in which the usual affections and operations of these regions are carefully described and illustrated. The article on surgery of the mouth and tongue by Dr. Henry H. Mudd of St. Louis is short and entirely without illustrations. One would think there ought to be wood-cuts or plates to illustrate the description of the various methods of excision of the tongue. Passing over the article on the surgery of the salivary glands, neck, chest, eye and ear, all of which are deserving of notice, we pause to note that Dr. Louis McLane Tiffany of this city contributes an interesting article upon the surgical diseases of the jaw and teeth. Excellent articles on the surgical diseases of the skin and on syphilis are presented by Dr. W. A. Hardaway of St. Louis and Dr. R. W. Taylor of New York.

By all odds the most elaborate and meritorious section in this volume is that which

appears under the joint authorship of Drs. J. William White and Wm. H. Furness, 3rd, of Philadelphia. This is the part devoted to the consideration of the surgery of the genito-urinary system and is a volume in itself, occupying, as it does, 331 pages. In this article all the surgical affections of the kidneys, ureters, bladder, prostate, testicles and penis are exhaustively considered. As might be expected, White's operation of castration for the relief of enlarged prostate and its accompanying cystitis is discussed at considerable length and earnestly advocated.

**ANTISEPSIS AND ANTISEPTICS;** by Charles Milton Buchanan, M. D., Professor of Chemistry, Toxicology and Metallurgy, National University, Washington, D. C., with an Introduction by Professor Augustus C. Bernays. Newark, N. J.: The Terhune Company. 1895.

This little book contains a very comprehensive history of antiseptics and antisepsis. After the historical account there is an alphabetical list of the antiseptic substances with a short account of each. Several proprietary articles which have shown themselves to be worthy of record are included in this list. The opinions of the best known surgeons are grouped at the end of the volume. The work apparently leaves nothing undone and is of historical and practical interest.

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#### REPRINTS, ETC., RECEIVED.

**The Surgical Technique of Asepsis.** By H. O. Marcy, A. M., M. D., LL.D., of Boston. Reprint from the *Journal of the American Medical Association*.

**Recto-Vaginal Fistulae and Fistulae about the Anus in Women.** By A. Lapthorn Smith, B. A., M. D., etc., of Montreal. Reprint from *Mathews' Medical Quarterly*.

**A Clinical Lecture on the Treatment of Chronic Glandular Gastritis (First Stage).** By Fenton B. Turck, M. D., of Chicago. Reprint from the *Therapeutic Gazette*.

**Personal Service as the Especial Exponent of a Great Profession,** By H. O. Marcy, A. M., M. D., LL.D., of Boston. Reprint from the *Boston Medical and Surgical Journal*.

**Demonstration of New Methods of Diagnosis and Treatment of Diseases of the Stomach and Intestines.** By Fenton B. Turck, M. D. Reprint from the *American Medico-Surgical Bulletin*.

#### Current Editorial Comment.

##### THE PHYSICIAN'S DUTY.

###### *Medical Summary.*

It is not only important that the physician should be ready to obey the calls of the afflicted, but his mind should also be impressed with the greatness of his mission and the responsibility incurred in its discharge. These obligations are of course the more deep and enduring because there is no tribunal, other than his own conscience, to adjudge the penalties for carelessness or neglect.

##### BACTERIOLOGISTS.

###### *Medical Record.*

BACTERIOLOGISTS are useful assistants, but they are tyrannical masters, and the results of a given treatment must after all be judged, not in the laboratory, but in the hospital ward and the sick-room. A check must be imposed on garrulous bacteriologists who show a disposition to ride the cockhorse among us. We are grateful to them for such assistance as it may be in their power to render to medical science, but we cannot allow them to dictate to us what conclusions we are to draw from clinical investigation. Bacteriological statements are matters of inference, but clinical observations are facts;—facts, too, which concern us more nearly than the interesting, but too often contradictory, deductions which foreign laboratory men foist upon us at the point of the scalpel.

##### CONSENT IN OPERATION.

###### *Peoria Medical Journal.*

LEGALLY considered, to justify a surgical operation upon a married woman, her consent and not that of her husband is necessary. A married woman cannot be compelled to submit to an operation; but if she voluntarily submit to its performance her consent will be presumed, unless she was the victim of fraudulent misrepresentation. Even if the disease resulting in death was caused by the operation, the surgeon is not liable if he performed the operation with the patient's consent, in a careful and skillful manner, and under the belief that it was proper to be performed. The person who allows a surgical operation to be performed is presumed to have employed the surgeon for that particular purpose, and it will be presumed that the operation was carefully and skillfully performed in the absence of proof to the contrary.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### MEDICAL LIBRARIES; THEIR DEVELOPMENT AND USE.

READ BEFORE THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND AT THE  
FORMAL OPENING OF THE NEW HALL AND LIBRARY, JANUARY 11, 1896.

By James R. Chadwick, M. D.,  
Librarian of the Boston Medical Library Association.

In accepting Dr. Osler's invitation to give to you a short address upon the medical library, its development and use, at the inauguration of the new building of the Medical and Chirurgical Faculty of Maryland, I find myself handicapped by lack of time for adequate preparation and an experience which is restricted to one locality, the city of Boston. Still I have had practical knowledge of the building up of a library from a few hundred to twenty-six thousand volumes and twenty-three thousand pamphlets. The lessons learned in the twenty years of labor may not be devoid of interest and value to you.

Soon after a young man graduates from the medical school and assumes the responsibility of the lives and health of his fellow beings, he soon realizes the limitations of his knowledge, and looks about to remove them. He finds two principal means of adding to his meager acquisitions, hospitals and books. Hospitals, including dispensaries, if assiduously frequented, certainly teach him more of immediate practical value than do books. But the knowledge there acquired does not always bear upon the particular case in his private practice which is causing him anxiety, and, moreover, the hospital has the disadvantage

of being available only during certain hours of the day, and of necessitating absence from his field of labor during the hours when he ought to be earning his livelihood.

To the printed words of his masters and colleagues he must consequently turn and where shall he find them? His own few shelves contain the treatises from which he learned the first rudiments of his knowledge, but in our day every one of these is superseded in two or three years by the rapid advance of medical science.

In the early years of practice, few men can afford to buy or even give shelf-room to a tenth part of the books that they need; no man, whatever his means, can possibly acquire all. A library is consequently indispensable in every center of population, or the health and lives of the community will be jeopardized by the ignorance of its medical practitioners. Could this fact be realized by the liberal men of means in our midst, self protection, if no higher motive, would stimulate them to endow our medical libraries with as free a hand as they now evince toward hospitals. The benefits conferred upon suffering humanity would be greater, though less manifest to the ordinary man of wealth.

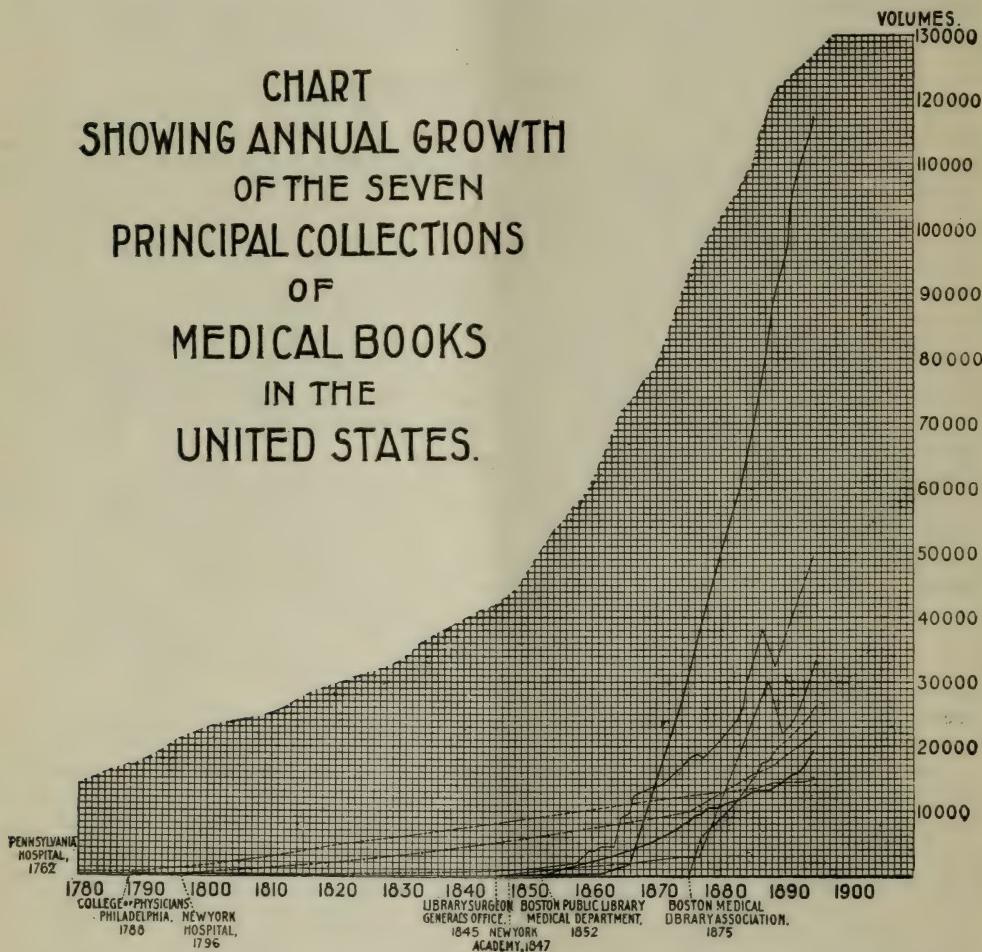
Admitting then, that a medical library for the use of the profession in every community is indispensable, and recognizing that we must not expect many contributions from the public, by what direction of our efforts can we procure it?

I appreciate that you do not need to be told how to make a start, for I well know that in the thirty-third year of your age (1832) you established a library in

the larger medical libraries of the country.

As a stimulus to fresh effort to increase your already large library, I have had this chart constructed showing the yearly rate of growth of the seven largest collections of medical books in the country. An explanation of the peculiarities of the curves will throw much light on the various means by

## CHART SHOWING ANNUAL GROWTH OF THE SEVEN PRINCIPAL COLLECTIONS OF MEDICAL BOOKS IN THE UNITED STATES.



your Society under the fostering care of Dr. Samuel Baker; that in 1852 the first catalogue was published by Dr. John W. Woods; and that a few years later Dr. George W. Miltenberger raised funds for the increase of the library with such marked success that you already possess about 10,000 volumes, ranking among

which the growth of each library has been effected.

The first library to be founded was that of the Pennsylvania Hospital in 1762; there has been a comparatively steady increase to the present day, no annual enumeration having been made. It now numbers 15,007 volumes. The

difficulty of procuring books in the last century and the early decade of this can be appreciated from a printed circular distributed about 1805 to the members of the Second Social or Boston Medical Library in which it is stated that "the books ordered last year from Europe have not yet been received."

The second library in order of seniority is that of the College of Physicians in Philadelphia, which was commenced in 1788. Its curve of growth shows such great fluctuations that a brief study of them will be profitable in making evident the means by which a library is augmented. You will note that the increase was very slow for sixty years, when in 1858, 1265 volumes were received from Dr. Thomas F. Betton. In 1864-5 the library was almost doubled in size, chiefly by the gift of 2500 volumes from Dr. Samuel Lewis, who from that date until his death was a constant contributor to its alcoves, the aggregate of his donations ultimately reaching the grand total of nearly 10,000 volumes. The erection of a fire-proof building in 1864 also contributed to securing many accessions. Between 1882 and 1886 the growth was very rapid owing to the receipt successively of the libraries of Dr. William F. Jenks, Dr. Alfred Stillé, Dr. Samuel D. Gross, Dr. I. Minis Hays, Dr. John S. Perry and that of the Obstetrical Society of Philadelphia.

In 1880 to 1882 Dr. S. Weir Mitchell contributed \$2000 as a journal fund, and later, when president, aroused by his love of books and his enthusiasm, the greatest interest in the library, whereby it grew rapidly. The falling off of its curve and that of the New York Academy of Medicine in the eighties merely means that duplicates were thrown out. The College now contains 49,747 volumes, besides 28,384 unbound pamphlets, reports and transactions.

The library of the New York Hospital was founded in 1776, had a steady increase until 1876 when, like all the others, it took on a more rapid growth. It now numbers 22,383 volumes but has practically no pamphlets.

The library of the Surgeon-General's Office in Washington, began in 1845, grew so slowly that in 1865 it contained less than 2000 volumes. Its increase from that date has been so phenomenal that we are warranted in pausing to seek an explanation, which is not, however, hard to find. It was in that year that a young army surgeon, Dr. John S. Billings, who had shown literary tastes and marked executive ability during the war of the rebellion, was detailed to take charge of this insignificant collection of books. He at once conceived the idea of developing this nucleus into a grand national library. By importuning Congress year after year he secured large annual appropriations of money (the annual appropriation for the purchase of books has averaged nearly \$7000 from 1867 to 1895 inclusive), and by persistently canvassing, personally and by letters, the profession of every State in the Union he secured large donations of books. Exchanges were effected with other medical libraries not only in this country but in all parts of the world. From these two sources about one-sixth of the total number was derived. The result of his labors is the most complete medical library in the world, consisting of 116,847 volumes and 191,598 pamphlets.

The influence of this one man's work is not seen in the growth of this library only, but is made manifest by the impetus given to all existing libraries and to the formation of innumerable new ones, of which my data are still incomplete. The publication of the index-catalogue of this library, the first series of which, in sixteen volumes, was begun in 1879 and completed in 1895, will, when the new series of five or six volumes is issued, be practically an index to all the medical literature of the world up to the end of this century.

Its value to medical scholars is inestimable, superseding, as it does, all the time-wasting labor that used to be expended in bibliographical research. By its aid we obtain a reference to every rare case that has been recorded since printing was discovered in A. D., 1450. But by indexing the articles and reports

of cases in every periodical, past and present, obscure or famous, this catalogue has immensely extended the scope of medical research and created a demand for an array of books, and especially of periodicals, that is simply appalling. What is an earnest seeker after knowledge to do when he has, for instance, a case of inflammation of the pancreas and refers to this catalogue for the writings on the subject, when he discovers a reference to a case in the *Medizinische Jahresbericht von Peter-Pauls Hospital* in St. Petersburg, to another in the *Bulletino di Scienzia medica di Bologna*, to another in the *Moniteur scientifique* and to another in the *Zeitschrift für die gesammte Medizin* of Hamburg, and so on *ad infinitum?* He cannot possibly have complete files of these various periodicals upon his own shelves. He must have within reach a library, in which most, if not all, these volumes may be found, or he will fail to learn all that can be learned about this subject and, as a consequence, his patient will suffer from treatment based on half knowledge.

The demand thus created for periodicals of all kinds and countries has done more than anything else to promote the growth and foundation of public medical libraries throughout our country. This publication is therefore the great factor in determining, during the past fifteen years, the rapid rise of the curves of all the libraries represented upon this chart. The pressure of the demand for an extensive literature thus created will never wane.

The library of the New York Academy of Medicine, inaugurated in 1847, had the same slow growth as all the others until 1876-7, when Dr. S. S. Purple gave to it his large collection of medical periodicals. Its subsequent rapid growth owed much of its impetus to the energy of my old and dear friend, Dr. Fordyce Barker, who, combining the wisdom of age and the enthusiasm of youth, was foremost in securing funds for a new building in 1880, when he was president. In 1890 a new impetus was given to this library by the erection of a superb new fire-proof building. This library is fast becoming

worthy of the metropolis of our country. It contains 33,140 volumes and 13,000 pamphlets.

The Medical Department of the Public Library of Boston was founded in 1882 and has grown, by purchase and gifts, at a comparatively uniform rate. It now contains 19,609 volumes.

The Boston Medical Library Association, of which I have been the librarian since its foundation, in 1875, has had a rapid growth from the outset, chiefly because, in its early years, it took into its fold the libraries of several local societies. Its growth has been almost entirely by donations and exchange, having no funds regularly available for the purchase of books.

Its value is greater than its size would indicate for the reason that nearly 16,000 of its 26,000 volumes are periodicals and this class of literature is of most practical value to the medical public. The completeness of our files of journals and transactions I attribute largely to the existence of the volume which I hold in my hand, my "want-book," wherein, upon the left hand page, is entered every periodical of which we have any part, while on the opposite page is entered every volume or number needed to complete the file of that particular journal. By invariably carrying this with me upon my travels in this country and Europe, I have been able gradually, at a trifling expenditure of money, to complete the files of all the leading periodicals of the world. I submit this to your special attention if you wish to know how to build up a medical library with practically no funds for the purchase of books. This library now contains 26,082 volumes, and 23,595 pamphlets.

I have sought by the analysis of these curves to indicate the principal factors in the growth of a medical library. The lessons to be drawn from this enumeration are that if a valuable collection of books is accumulated, the profession will rally to supply for it a suitable abode, and, as my friend, Oliver Herford, says, "It's a poor pill that will not work both ways," so we find that if a fine building is erected the library will

soon be forthcoming. In either and every case some one man must work early and late to secure contributions and especially to make complete the files of periodicals.

I would not be understood as intimating that money is not needed for the building up of a library. As the Chinese say, "With money you can move the gods; without it you cannot move a man." Money and much money is needed for the maintenance of a library. The continuous service of a librarian and perhaps one or two assistants must be paid for. Many hundred volumes must be bound every year. A certain number of periodicals must be secured for your reading-rooms as soon as published and therefore by subscription. The list of these may be supplemented immensely by securing gratuitously the exchanges of your medical journals, the journals received by your instrument-makers and manufacturing chemists, etc., in return for their advertisements, the journals circulated in journal clubs of medical men after they have gone the rounds. You may also obtain in exchange for your own transactions the publications of nearly all kindred societies.

Finally, an author, subject and title card catalogue must be kept up to date, no matter what the expense. "Who wants a lock without a key, a ship without a rudder, a binnacle without a compass, a check without a signature, a greenback without a goldback behind it?" (O. W. Holmes.)

Finally, I want to say a word about pamphlets, with regard to which you will have noticed that policies differ widely; the New York Hospital keeps no pamphlets, the Surgeon-General's Library has sixty per cent. more pamphlets than books, the Academy of Medicine has only one-third as many pamphlets as books. Some of this discrepancy is doubtless due to different relative classifications of books and pamphlets. In order to secure uniformity, the rule of the Washington Library should be universally followed: to classify as a pamphlet everything that is unbound, up to a hundred pages, and everything that contains less than thirty pages, even though

bound; to classify as a book everything above thirty pages, if bound, and everything above one hundred pages, even though unbound. This is purely arbitrary and may not be invariably followed, but it is as fair a classification as can be devised. No accurate comparison of the size of the different libraries can be made if, as in my knowledge has happened, one library counts everything above thirty pages as a book, whether bound or unbound. It may thus surreptitiously add many thousand volumes, so-called, to its aggregate of books and take thereby an illegitimate rank among the libraries.

Pamphlets should be carefully kept and catalogued in one library in every city. They include most of the graduating theses, which are often compilations of inestimable value; they often contain the results of extensive laboratory experiments; they contain much local history, reports of special committees who have investigated water supply, drainage, epidemics, quarantine, etc. Even reprints of journal articles are of use, even though the library has the file of the journal in which they appear, because they may circulate for home reading when the journal may not be allowed to leave the building.

Classify your library by subjects, making the subdivisions more numerous from time to time, as the books accumulate. Do not agree to keep a man's library, if on various subjects, together as a unit, if you can help it, for you thereby break in upon your regular system of classification and make the library harder to administer and less available to the readers, besides storing many duplicates uselessly.

As to the use of the books, make it as free as is consistent with their safety. Where the users of a library are all members of an association and consequently known personally to the custodian, it is generally deemed safe to allow them free access to the shelves. All books that can be readily replaced may circulate for home reading, but not periodicals, for the loss of one volume of these depreciates the value of the whole series.

It is useful to make duplicate files, as occasion presents, of the leading periodicals for home reading. Beyond this be liberal in the disposal of duplicates; there is no market for medical books, so you may as well bank on the future, by giving freely of your duplicates to other kindred institutions on open exchange account, which is never meant to be balanced. You thereby establish a claim upon such institution for any favor it may be in position to do you in the future.

But I find that I am dropping into

technical details that can have no interest for any one but your librarian and committee on the library.

In conclusion, I want to parry the charge of having too prosaic a view of a medical library, of seeing only the utilitarian side of it. To the deep student, to the true lover of books, nothing that I can say will add or detract from his appreciation of it. Remember what Confucius says, "Learning without thought is labor lost; thought without learning is perilous."

## SIMPLE PROPHYLAXIS OF NASAL DISEASE.

*By John R. Winslow, B. A., M. D.,*

Clinical Professor of Throat and Nose, Woman's Medical College; Throat Surgeon Presbyterian Eye, Ear and Throat Hospital; Fellow American Laryngological, Rhinological and Otological Society.

THE nose is, or should be, the portal of entry of the air we breathe. During its passage through the nasal chambers the air is prepared and rendered suitable for respiration in the lower respiratory organs. This preparation is essential and upon its proper performance depends the health not only of the respiratory tract, but even of the entire organism.

Thus the nose bears a hygienic relation to the entire body, and when it is deranged, those organs that are directly or indirectly connected with it must sooner or later be also affected. This is particularly true of the throat and lungs, and many diseases so common to these parts take their origin in deranged nasal functions. Indeed many writers hold the opinion that most of the chronic affections of the lungs are principally due to improper nasal respiration. Certainly it has been abundantly demonstrated that even such serious disease as pulmonary phthisis is markedly benefited by suitable treatment of co-existing nasal affections.

Now one of the important functions performed by the nasal apparatus is the removal of dirt from the inspired air, both visible material, as well as the micro-organisms of disease. Every individual with any care for health and

cleanliness performs certain daily ablutions which are termed "the toilet." Although the nose is one of the most uncleanly organs of the body, it is seldom included in this routine. That this essential process of cleansing the nostrils is wofully neglected, any of us who has occasion to examine many of these organs can attest.

With a normal condition of the nose, then, simply as a matter of ordinary cleanness the toilet of this organ should be added to that of the face, hair and teeth.

Turning now to the pathological side of the subject, while I have no intention of entering upon a discussion of the treatment of chronic nasal catarrh, it has occurred to me that by attention to its early stages, many of these conditions might be avoided and destructive operations with cautery and knife diminished in frequency.

And firstly, I would urge it upon the profession that we should never neglect a coryza or "cold in the head." Even in simple acute inflammations of the nasal mucous membrane there is gradually established by repeated attacks a permanent alteration, which eventually results in chronic nasal catarrh.

But what we term acute coryza is

frequently the invasion of an infectious micro-organism, with resulting inflammation which may extend to the Eustachian tubes and ear, larynx, trachea and lungs. Thus Ziem draws the conclusion from extensive observations, that the nose is the usual gate of entry of these organisms. They penetrate not only the nasal chambers, but enter the accessory sinuses in communication with them. Wolff of Hamburg has demonstrated the presence of staphylococci, streptococci and diplococci in the accessory sinuses after cases of diphtheria, scarlet fever and even measles. In nasal diphtheria virulent bacilli were found in the antrum four months after apparent cure. In scarlet fever and measles the accessory sinuses were always found affected. The more extensive my own experience becomes in affections of the accessory cavities of the nose, the more I am convinced that many if not most of them are ushered in by an acute coryza, so-called.

The lesson lies upon the surface that not only should we never neglect even an apparently simple cold in the head, but that in addition to the well known constitutional remedies, and especially in influenza, scarlet fever and measles, we should apply well directed antiseptic douche treatment to the nasal mucous membrane and as long as symptoms of irritation are present. For this purpose we may use warm one per cent. salt solution, Seiler's, Dobell's, etc., properly diluted.

The second point to which I desire to draw attention is earlier treatment of the antecedent stages of chronic nasal inflammation. These cases seldom come under the care of the specialist, and there is little occasion that they should. Unfortunately when they do apply to their physician for treatment they are often either told that "it will get all right," or are put under a vigorous and irritating spray regime, which only hastens the inevitable result, chronic nasal catarrh. What they require is a word of intelligent advice, and a simple, efficient and harmless method of treatment, which can be carried out at home with little trouble or expense.

I fully agree with the writer who, in speaking of nasal catarrh, says that the proper systematic use by the patient of an antiseptic cleansing fluid will do more to restore the mucous membrane to its normal condition than the specialists' treatment, and that this treatment without such assistance is deceptive and inefficient. How much more, then, will suitable and timely treatment prevent the establishment of this condition.

The symptoms presented by these cases are very variable. One of the most prominent is occlusion of the nostril, varying from side to side and most marked at night, or when lying down. This is due probably to some vaso-motor disturbance and temporary engorgement of that turbinate body which is most dependent. Then there are various indefinite symptoms due to perverted nervous function. Thus many patients complain of an almost intolerable itching inside the nose, others simply of a general uncomfortable feeling which they are unable to describe, others of a feeling of tension at the bridge of the nose, etc.; all of them premonitory symptoms, which should not be dismissed as trivial and should lead us to institute prophylactic measures. Examination of the nose shows little more than slight congestion of the mucous membrane.

*Treatment.*—At the outset, I wish to condemn unqualifiedly the so common direction, "snuff salt water up your nose." Either it does not pass beyond the vestibule of the nose, or if sufficient force be used, it may be aspirated into the middle ear with permanent damage. Moreover, in the strength in which it is used by the laity, saline solution is by no means the unirritating fluid that is commonly supposed. Unless prepared in powders, tablets, or some definite subdivision, so that the strength of the solution shall not exceed one per cent., salt had best not be used, its very simplicity and commonly reputed harmlessness being its dangers. As a cleansing agent a more efficient substitute is cooking soda, which I direct to be used warm in a two per cent. solution (3j—about a

tumblerful). This should always precede other measures.

For therapeutic effect I have tried most of the "ines" and "ols" that are offered in ever-increasing numbers, first to the profession and then to the public. One of the latest of these actually turned sour (fermented) upon my office table, a proof positive that it possessed not the slightest antiseptic virtue. The numerous tablets of attractive formula that are furnished soon become hard and insoluble, so that considerable time and trouble are required in their use. These I always order to be crushed and, when possible, rubbed up in glycerine.

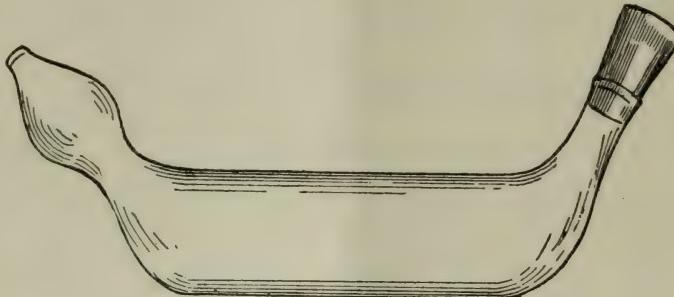
For my own purposes in the office I have discarded these, so to speak, "ready-made" preparations and em-

method and solution are adaptable to the nasal douche. The advantages of this method are several. It is cheap, the original powder costing about seven cents an ounce, a small quantity of which makes a pint of the saturated solution, of which but a few drops are used at a time.

It is already in solution, or can be prepared at a moment's notice.

It is a method by which we can instantly prepare a warm spray of proper strength from our hot water faucet, which I have found a distinct advantage.

With regard to the means of applying these cleansing and antiseptic solutions we have an efficient instrument and one that is safe to put in hands of patients in



ONE-THIRD SIZE.

ploy the following powder, an amplification of that of Professor Karl Stoerk of Vienna.

R.—	Kalii Chlorat.	
	Sodii Chlorid.	aa. 15.0 ( 3ss)
	Sodii Biborat.	
	Sodii Bicarb.	50.0 ( 3j 3ivss)
	Sodii Salicyl.	15.0 ( 3ss)
	Acidi Carbol.	2.0 ( 5ss)
	Menthol	
	Eucalyptol	{ aa. 1.c (gr. xv)
	Thymol	

This I keep in a wide-mouthed, glass-stoppered bottle and from it I can prepare at any time the saturated solution in water and ten per cent. glycerine which I always have ready. Of this saturated solution I add from a few drops to a drachm to a spray tube full of warm water, regulating the strength more by the feelings of the patient than the actual quantity in solution. The same

the form of the nasal douche-tube or douche-cups. These are modelled, all of them, after the "schiffchen" which was in daily use in Politzer's clinic in Vienna several years before their appearance in this country. Each of these has its advantages and disadvantages, which I do not undertake to discuss.

We have introduced at the Presbyterian Eye, Ear and Throat Hospital a douche-tube which, it seems to me, presents certain advantages over the others.

1. It is cheaper than any other that is of efficient size (one ounce).

2. Its nose-piece joins the body at an obtuse angle, so that it is not necessary to nearly dislocate the neck in order to cause the fluid to run back through the nostrils. (See cut). This, together with a similar douche, termed No. 10, was made for me by Whitall, Tatum & Co. and can be obtained from them.

The method of use is as follows: The tube is held between the thumb and index finger, the middle being over the air inlet. The nose-piece is introduced into the nostril with tube vertical, the chin is thrown forward and the head slightly backward, over a basin. The flow of fluid is controlled by the finger over the air inlet and when it is removed the pressure of the column of water is sufficient to force it through the nose. The flow can be arrested at any time, simply by placing the finger over the

air hole. By directing the patient to pant or pout constantly during the procedure, the palate is elevated, the fluid flows in a continuous stream into the nostril, around the septum and out through the opposite nostril. Patients are directed to wash twice with warm soda solution through each nostril, and then once with an antiseptic wash, after which they are directed not to blow the nose, but simply to wipe the outside.

The results of this treatment have been eminently satisfactory.

## WATER POLLUTION.

THE FOLLOWING BILL HAS BEEN PREPARED WITH THE OBJECT OF PREVENTING THE POLLUTION OF STREAMS TRIBUTARY TO THE WATER SUPPLY OF BALTIMORE.

IT WILL BE PRESENTED TO THE MARYLAND LEGISLATURE AT AN EARLY DATE.

**SECTION 1.** Be it enacted by the General Assembly of Maryland :

That no privy or place for the deposit or storage of human excreta shall be constructed, located or maintained within 100 feet, horizontal measurement, of the high water mark of any lake, pond or reservoir, or within 75 feet, horizontal measurement, of the high water mark or precipitous bank of any spring, stream or water course of any kind tributary to said lakes, ponds or reservoirs on the entire water-shed of the streams now used for the water-supply of the City of Baltimore, and whenever practicable these distances shall be 150 feet and 75 feet respectively.

**SECTION 2.** And be it further enacted, That no privy-vault, pit or cess-pool or non-transportable receptacle of any kind for the reception or storage of human excreta shall be constructed, located or maintained within 300 feet, horizontal measurement, of the high water mark of any lake, pond or reservoir, or within 150 feet, horizontal measurement, of the high water mark of the precipitous bank of any spring, stream or water course of any kind on the entire water-shed of the streams now used for the water-supply of the City of Baltimore.

**SECTION 3.** Every privy, or the place

for the deposit of human excreta, which is constructed, located or maintained between the aforesaid limits of 75 feet and 300 feet, horizontal measurement, of the high water mark of any lake, pond or reservoir, or within the limits of 75 feet and 150 feet, horizontal measurement, of the high water mark or precipitous bank of any spring, stream or water-course tributary to such lakes, ponds or reservoir on the entire water-shed of the streams now used for the water-supply of the City of Baltimore, and from which the said excreta are not at once removed automatically by means of suitable water-tight pipes or conduits to some proper place of ultimate disposal as hereinafter provided, shall be arranged in such manner that all such excreta shall be received and temporarily maintained in suitable vessels or receptacles, which shall be at all times maintained in an absolutely water-tight condition, and which will admit of convenient removal to some place of ultimate disposal as hereinafter set forth.

**SECTION 4.** Whenever it shall be found that, owing to the porous character of the soil, the height and flow of the surface and subsoil waters, the steepness of the slopes or other special condition of the locality, the excremental matter

from any privy, cess-pool or other receptacle for human excreta, situated within the limits hereinbefore provided, may be washed over the surface or through the subsoil into any lake, pond or reservoir, or into any spring, stream or water-course tributary to such lake, pond or reservoir on said water-shed of the streams now used for the water-supply of the City of Baltimore, without having been thereby, in the judgment of the State Board of Health, sufficiently purified, then the said privy, cess-pool or other receptacle for human excreta shall, after due notice to the owner thereof, be removed to such greater distances from said high water marks as shall be considered safe and proper by the State Board of Health.

SECTION 5. All said receptacles for human excreta must be provided with tightly fitting covers, which shall be securely applied during the process of removal, so that no portion of the contents of said receptacle shall escape therefrom while being transported from the privy to the place of ultimate disposal.

SECTION 6. A sufficient number of duplicate receptacles of said general description or character shall be provided, so that when one of the same is removed from the privy, an empty receptacle may at once be substituted in its place.

SECTION 7. All such receptacles when filled shall be removed to some place of ultimate disposal as hereinafter provided, and said receptacles themselves shall be thoroughly cleansed and disinfected as often as may be found necessary to maintain the privy in proper sanitary condition and to prevent an overflow of the excreta upon the soil or floor of said privy.

SECTION 8. The excreta collected in the aforesaid receptacle shall be removed to some convenient place of ultimate disposal which shall not be less than 500 feet from the high water mark or precipitous bank of any lake, pond or reservoir, and not less than 300 feet from the high water mark or precipitous bank of any stream, spring or water-course of any kind on the entire watershed of the streams now used for the water supply of the City of Baltimore,

and which then cannot be directly washed by rain or melting snow, or otherwise over the surface of the ground into any lake, pond or reservoir or into any spring, stream or water-course, channel or well which is tributary thereto on the entire water-shed of the streams now used for the water-supply of the City of Baltimore.

SECTION 9. In the absence of any other manner of disposal of the excreta collected as aforesaid, which is not specifically approved by the State Board of Health, after the submission to said Board the said excreta shall be disposed of by digging the same into the surface soil or by burial in trenches of moderate depth in places where the character of the subsoil and the depth of the ground water level will afford ample security both against undue pollution of such ground water and the soil itself, and for the efficient filtration of the liquid contents of the said receptacles.

SECTION 10. The removal of the aforesaid receptacles from the privies shall be conducted in such manner as to cause as little inconveniences or annoyances to the occupants of the premises as is compatible with proper management of the work.

SECTION 11. No sewage, house slops, sink wastes, water in which clothing or bedding has been washed or rinsed, nor any other polluted water or liquid shall be thrown or discharged directly into any lake, pond or reservoir, as aforesaid, or into any spring, stream or water-course tributary thereto, nor shall any such aforesaid liquid matter or any other polluted liquid be thrown or discharged upon the surface of the ground or into the ground below the surface in any manner whereby the same may flow into any lake, pond or reservoir, or into any spring, stream or water-course tributary thereto, within 75 feet, horizontal measurement, of the high water mark in any lake, pond or reservoir, or within 75 feet of the high water mark or the precipitous bank of any spring, stream or water-course tributary to said lakes, ponds or reservoirs and wherever practicable these distances shall be 150 feet and 100 feet respectively.

SECTION 12. The foregoing requirement shall be considered applicable only where the quantity of such polluted water or liquid waste is small, such as may be derived from a single family, but when relatively large quantities of such waste are produced and are thrown or discharged upon or below the surface of the ground at any point beyond the aforesaid limits, in such manner or volume as to cause the same to flow over the surface of the ground, or through it below the surface into any lake, pond or reservoir, or into any spring or water-course tributary thereto, without having been thereby, in the judgment of the State Board of Health, sufficiently purified, then, upon due notice to the owner or occupants of the premises from which such discharge comes, the aforesaid distances shall be increased respectively to such other limit as shall appear justified to the State Board of Health.

SECTION 13. In case that human excrement is mingled with any of the aforesaid polluted water or other sewage, the discharge of the same upon or below the surface of the ground will be governed by the rule relating to privies.

SECTION 14. No clothes or unclean objects of any kind shall be washed in any lake, pond or reservoir or in any spring, stream or water course tributary thereto.

SECTION 15. No garbage or putrescible refuse of any kind shall be thrown or discharged directly into any lake, pond or reservoir or into any spring, stream or water-course tributary thereto; nor shall any such substance be placed in large quantities upon or below the surface of the ground where they may be washed into any lake, pond or reservoir or into any spring, stream or water-course tributary thereto within 150 feet of the high water mark of any lake, pond or reservoir, or within 100 feet of the high water mark or precipitous bank of any spring, stream or water-course tributary to said lakes, ponds or reservoirs. And wherever possible these distances shall be 300 feet and 150 feet respectively.

SECTION 16. The State Board of Health shall have the right to increase

the aforesaid distances in all cases where, in its judgment, it may appear that injury to the purity of the water results from the deposit or storage of garbage or putrescible refuse as aforesaid.

SECTION 17. Where it becomes impracticable to comply with the foregoing requirements so far as the disposal of garbage or putrescible refuse upon or below the surface of the ground is concerned, then suitable water-tight receptacles must be provided and be so located and maintained on the premises that none of the contents thereof shall escape and pollute the waters as heretofore indicated.

SECTION 18. No stable, pigsty, hen house, barn yard, hog yard, hitching or standing place for horses or cattle or other place where animal manure accumulates, shall be constructed, located or maintained within 150 feet of the high water mark in any lake, pond or reservoir or within 75 feet of the high water mark or precipitous bank of any spring, stream or water-course tributary to said lakes, ponds or reservoirs; and wherever possible, these distances shall be 300 feet and 150 feet respectively.

SECTION 19. No stable, pigsty, hen house, barn yard, hog yard, hitching or standing place for horses or cattle or other place where animal manure accumulates, shall be arranged or maintained in such manner that the washings or drainage therefrom may flow through open or covered drains or channels into any pond, lake or reservoir or into any spring, stream or water-course tributary thereto, without having undergone proper purification.

SECTION 20. The foregoing requirements shall also apply to composts and to masses of fermented or decayed fruit, vegetables, roots, grain, sawdust, leaves or other vegetable substances which may be used either alone or in combination with other matter as manure or as food for domestic animals.

SECTION 21. No dead animal, bird, fowl, fish or reptile or parts thereof or any filthy or decaying matter of animal or vegetable origin, derived from human habitations, barns or stables, nor any putrescible matter or waste product or

polluted liquid from any slaughter houses, creameries, condensed milk factories, cheese factories, breweries, distilleries, cider mills, wine or beer vaults, sugar or glucose factories, tanneries, woolen mills, paper mills, pulp mills, saw mills, gas works or other manufactory shall be thrown, discharged, drained or washed into any lake, pond or reservoir or into any spring, stream or water-course tributary thereto.

**SECTION 22.** No dead animal, bird, fish, fowl or reptile or any part thereof shall be buried in the ground within 300 feet of the high water mark of any lake, pond or reservoir or within 150 feet of the high water mark or precipitous bank of any spring, stream or water-course tributary thereto.

**SECTION 23.** No live sheep or other animals shall be washed in any lake, pond or reservoir, or in any spring, stream or water-course tributary thereto; neither shall any person swim, bathe, or wash in any of said lakes, ponds or reservoirs, or in the streams tributary thereto.

**SECTION 24.** The waste liquids which may be polluted with putrescible or deleterious organic matter from any of the operations above indicated shall be thoroughly filtered or otherwise purified before being allowed to escape into any lake, pond or reservoir or into any spring, stream or water-course tributary thereto.

**SECTION 25.** No interment shall be made in any cemetery or other place of burial on the entire water-shed of the streams now used for the water supply of the City of Baltimore within 300 feet, horizontal measurement, of the high water mark in any lake, pond or reservoir or within 150 feet, horizontal measurement, of the high water mark or precipitous bank of any spring, stream or water-course tributary to such lakes, ponds or reservoirs.

**SECTION 26.** Whencever it shall be brought to the notice of the State Board of Health, that owing to the porous character of the soil, the height and flow of the subsoil waters, the steepness of the slopes, or other special conditions of the locality, percolation or drainage

from any cemetery or place of burial is polluting the waters of any lake, pond or reservoir, or of any spring, stream or water-course tributary thereto, the aforesaid limits within which interments are not permitted shall be extended as much further from said high water marks as shall be considered safe and proper by the State Board of Health.

**SECTION 27.** Wherever any system of treating excremental matter from any dwelling, hotel, stable, factory or other building from which such matter may be discharged by means of subsurface irrigation, filtration, chemical process or otherwise has already been established and now discharges the effluent liquid or solid matter anywhere within 500 feet, horizontal measurement, of the high water mark in any lake, pond or reservoir or within 300 feet, horizontal measurement, of the high water mark or precipitous bank of any spring, stream or water-course, tributary to such lakes, ponds or reservoirs on said water-shed, such discharges shall no longer be permitted, but must be carried to some suitable point beyond said limits respectively, unless especially allowed by the State Board of Health.

**SECTION 28.** Wherever any system of treating house slops, sink wastes, laundry water, stable drainage, factory wastes, or refuse, garbage or other putrescible waste matter or the drainage therefrom by means of subsurface irrigation, filtration, chemical process or otherwise has already been established and now discharges the effluent liquid or solid matter anywhere within 75 feet, horizontal measurement, of the high water mark of any pond, lake or reservoir, or within 50 feet, horizontal measurement, of the high water mark or precipitous bank of any tributary spring, stream or water-course such discharge shall no longer be permitted, but must be carried to some suitable point beyond said limits respectively, unless especially allowed by the State Board of Health.

**SECTION 29.** Any person or persons who violate, disobey, omit, neglect or refuses to comply with, or who resists any of the provisions of these statutes

shall be fined not less than fifty dollars nor more than one hundred dollars for each offence. Said fines to be collected as other fines are collected.

## Medical Progress.

**DIAGNOSIS AND TREATMENT OF GOUT.** — Gout in the young is not common, says Dr. Louis F. Bishop in the *Medical News*, and may be overlooked. The attacks occur suddenly, in the morning and in the great toe first. There is a remission in the morning and a recurrence the next night, and so on for several days. Suppressed gout is a form hard to make out. In gout there is an excess of uric acid in the blood. Chronic gout is easy to diagnose. The gouty patient is anemic, poorly nourished and often has a high tension pulse, an increased quantity of urine of low specific gravity with albumen and this is often put down as chronic diffuse nephritis.

There may be hereditary manifestations in other organs. There are immediate and remote manifestations of gout. Violent headaches may yield to a diet of milk and fish with no meat. Gout may attack the organs of special sense.

The management of a case of gout is chiefly a question of hygiene and diet, but this is not as easily carried out as many think. It is often a matter of experiment. Some persons can take meat, some starchy food and sweets. Lithia is recommended, but it should be given in definite amounts. Colchicum is still used by many and piperazine has advocates, but it is expensive. The iodides are excellent in chronic cases.

\* \* \*

**TEMPERATURE IN THE DIAGNOSIS OF TUBERCULOSIS.** — The diagnosis of obscure cases is greatly aided by the intelligent use of the thermometer. Dr. Walter Channing reports in the *Boston Medical and Surgical Journal* the diagnosis of a case of tuberculosis by the use of the thermometer for a long period.

He thinks the temperature fairly characteristic. Malaria, abscess of the liver and cancer were all gradually excluded. He says :

It would be interesting if a temperature curve could be plotted which might be regarded as characteristic, if not pathognomonic, of chronic tuberculosis. This can only be done by careful observations in a considerable number of cases. In the case under discussion the following points are brought out, which are, I believe, of significance from a diagnostic point of view, and of especial value in obscure cases, and, as far as they go, throw light on the temperature curve :

1. An average considerably above normal.
2. An almost invariable rise at night.
3. Periodicity of a maximum elevation of several degrees, occurring at irregular intervals of a few days.
4. Gradual ascent to the maximum for two or three days, with a decline sometimes gradual, sometimes sudden; the ascent at night, the decline in the morning.
5. Protracted continuance of a high temperature for months or years.
6. Less constitutional reaction from the periodical rises of several degrees, than would be expected.

\* \* \*

**AMINOL, AN ANTISEPTIC.** — Aminol (*American Medico-Surgical Bulletin*) is a preparation claimed to be the aqueous solution of a gas possessing antiseptic and deodorizing properties and is lauded as an excellent remedy against profuse diarrhea, tonsillitis, stomatitis, etc. L. van Italie describes it as a colorless, slightly turbid liquid, possessing the odor of trimethylamine, and exhibiting a strongly alkaline reaction to test-paper; specific gravity at  $17.5^{\circ}$  C. ( $62^{\circ}$  F.), 1.01. Chemical analysis showed that each liter contained calcium oxide 1.52 gramme, sodium chloride 3.516 gramme, and trimethylamine 0.289 gramme.

It is stated that bacteriological experiments proved aminol not to be a very reliable antiseptic.

## MARYLAND

## Medical Journal.

PUBLISHED WEEKLY.

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BALTIMORE, FEBRUARY 1, 1896.

IN view of the great interest at present shown in the State Faculty in its new building and the importance of the subject,

**The Faculty's Finances.** The report of Dr. Thomas A. Ashby, Treasurer of the trustees, is given here in full.

"At the annual meeting of the Faculty held in April, 1893, a Committee on Permanent Location was appointed to select a permanent home for the Faculty. A number of meetings of this Committee were held during the year, but no practical results followed. At the annual meeting held in April, 1894, the Committee reported progress and asked to be continued. A reorganization of the Committee took place and more active work was inaugurated. The Committee held frequent meetings, examined numerous pieces of property, discussed numerous financial schemes and finally arrived at definite con-

clusions. These conclusions were formulated in a report made at a special meeting of the Faculty held March 20, 1895. In this report the Committee recommended the following propositions:

"First, the purchase of house No. 847 North Eutaw Street, at a cost of \$10,000.

"Second, the authority to borrow in the name of the Faculty the sum of \$4000 at 5 per cent., payable within ten years from date of loan.

"Third, an increase of annual dues of city members from \$5 to \$6.

"Fourth, a commutation of annual dues to \$5 to all members who loaned \$100 to the Faculty for ten years at five per cent. interest.

"Fifth, the appointment of a board of ten trustees in whom the management and disposal of the property acquired by the Faculty should be vested.

"The various resolutions offered by the Committee were adopted by the Faculty and authority was thus given for the work which followed.

"The Committee on Permanent Location was then merged into ten trustees appointed by the president, who took up the work entrusted to them by the Faculty. The trustees at once organized and proceeded to carry into effect the resolutions adopted by the Faculty.

"The house 847 N. Eutaw Street was purchased in fee for the sum of \$10,000, \$3000 of which was paid in cash and the remaining \$7000 held by mortgage by the former owner, Mr. N. Rufus Gill, at five per cent. interest, the mortgage payable five years after date. A call for a loan of \$4000 was made upon the members of the Faculty with the following results:

32	members	loaned	\$100	each	.	.	.	\$3200
3	"	"	50	"	.	.	.	150
2	"	"	20	"	.	.	.	40
1	member	"	40	"	.	.	.	40
1	"	"	30	"	.	.	.	30
1	"	"	25	"	.	.	.	25
<hr/>								
40	members	.	.	.	total	.	.	\$3485

"Soon after the purchase of this property the trustees realized that the improvements on the Linden Avenue end of the lot were entirely unsuited to the uses of the Faculty and that it was absolutely necessary to remove these buildings and erect the present hall.

Whilst these improvements to the property necessitated an expenditure of some \$4000 more than the trustees were authorized to borrow, the way was opened to the trustees to make these improvements through the liberality of friends of the Faculty by which some \$2500 were given to the trustees for this purpose. After due consideration the trustees decided that they would assume the responsibility of raising the additional sum of money needed for these improvements. It was believed by the trustees that these improvements were imperatively demanded and that they should be made at once. They felt that the Faculty would subsequently ratify their action and grant authority if needed to raise the amount required to complete all of the improvements proposed.

"With these motives and conditions before them the trustees now exhibit their work to the Faculty with pride and confidence, feeling assured that the present property with all its improvements will meet all of the wants of the Faculty for years to come as a permanent home.

"In justification of their action the trustees now wish to present a financial statement showing the total cost of this property, the amount due on said property and the annual interest charged to the Faculty.

#### COST OF PROPERTY.

Amount paid Mr. N. Rufus Gill . . . . .	\$10,000
"    " for repairing shelving and furnishing old building . . . . .	1000
Amount paid and still due on new improvements (outside cost) . . . . .	4000
<hr/>	
Total . . . . .	\$15,000
<hr/>	
Amount due Mr. N. Rufus Gill . . . . .	\$7000
"    " members of the Faculty in loans . . . . .	3485
Amount loaned by Clinical Society . . . . .	1000
<hr/>	
Amount of Floating Debt . . . . .	1000
<hr/>	
Total . . . . .	\$12,485

"It will thus be seen by this report that the Faculty has acquired the present desirable home and hall sufficiently well furnished for all present needs at a total expense of \$15,000, on which there is an indebtedness of \$12,485,

at five per cent. interest, or an annual interest charge of \$622.25, an increase of \$22.25 over the rent of its former home on St. Paul Street. Let us, however, consider the comforts and conveniences of our present home and its increased earning capacity through rentals to the local societies and other sources of revenue, and no one can dispute the wisdom of the movement which has resulted in the purchase and improvement of this property. It now concerns the membership of the Faculty to consider thoughtfully and unselfishly how the present debt on the property can be paid off. The trustees have so far raised over \$2500 by donations of money, which sum has been expended on this property. There is now a floating debt of \$1000, which must be carried until donations are made to pay it off. The membership of the Faculty should come forward and subscribe liberally to this fund. I have no doubt this money can be raised in time, but the trustees need it now and it should be forthcoming.

"As the treasurer of the trustees I will agree to secure a cancellation of the notes now held against the Faculty to the extent of every dollar given to the floating debt given by the membership of the Faculty. In other words, if those members of the Faculty who have not previously loaned or given money to aid in the purchase of this property will raise the sum of \$1000, or any fraction thereof, I will use my best efforts to secure a cancellation of notes to the extent of such donations. I believe I can secure \$1000 in this way. Will you gentlemen of the Faculty raise \$1000 more? If you will, we can tonight or in the near future reduce the debt on this property to \$10,000. Both duty and pride in our time-honored organization demand the cancellation of this obligation. We owe it to ourselves and to coming generations of our profession to support this old Faculty and its Library on a more useful and more permanent basis. This present home should enlist our pride and co-operation in a larger work of professional organization and education in our State. What has been done in this respect in New York, Philadelphia and Boston should be done here.

"The only thing needed is the interest and liberality of the profession of our City and State in this direction.

"Let us tonight take a fresh start and devote ourselves generously to this work."

### Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending January 25, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		26
Phthisis Pulmonalis.....		26
Measles.....	112	1
Whooping Cough.....	6	1
Pseudo-membranous Croup and Diphtheria. {	11	4
Mumps.....	1	
Scarlet fever.....	12	1
Varioloid.....		
Varicella.....	4	
Typhoid fever.....	6	2

The street car companies of Baltimore are enforcing the rule against spitting in the cars.

A Philadelphia authority says that there will be started soon in that city a new medical journal to take the place of the *Medical News*.

Dr. Horatio N. Mackey, a well known physician of Morgantown, West Virginia, died in that place at an advanced age, on Tuesday, January 21.

The Mayor of Baltimore has appointed two physicians whose duty shall be to make regular inspections of the water-shed of Baltimore's water supply and report nuisances.

The Chair of Pathology has been abolished at the University of Michigan. The occupant of this chair was "imported" a few years since. The work will be distributed among other professors.

The Church Home on Broadway, Baltimore, will open a hospital for consumptives on the corner of Broadway and Fairmount Avenue. It will receive principally consumptive cases not admitted to other hospitals.

"Don'ts for Consumptives, or the Scientific Management of Pulmonary Tuberculosis," is the title of a book which, under the authorship of Dr. Charles Wilson Ingraham, will soon be issued by the Medical Reporter Publishing Company of Rochester, N. Y.

The question of prohibiting the use of matting and other textile fabrics upon the floors of public conveyances, lest they spread dis-

ease by collection in them of dried sputum and other morbid material, is now under consideration by the New York Board of Health.

The Medical and Surgical Society of Baltimore held its twenty-fourth anniversary and banquet last week. The following officers were elected: Dr. W. S. Gardner, President; Dr. R. G. Davis, Vice-President; Dr. S. T. Roeder, Recording Secretary; Dr. C. F. Blake, Corresponding Secretary; Dr. W. H. Schwatka, Treasurer.

The Baltimore Eye, Ear and Throat Charity Hospital on West Franklin Street, Baltimore, has published its fourteenth annual report. Over three thousand free patients have been treated in the different departments, and over eight thousand in the dispensary. A new building will probably be erected soon. Dr. Russell Murdoch is the Surgeon-in-Chief.

A bill has been introduced in the United States Senate providing that, in the District of Columbia, no physician shall be permitted, without the consent of the person afflicted, to testify to any facts coming to his knowledge in his professional capacity, and which were necessary to enable him to act in that capacity, whether such information shall have been obtained from the patient or his family, or from the person or persons in charge of him. This is not to apply to evidence in criminal cases and where the disclosure shall be required in the interest of public justice.

The contents of the *Journal of Experimental Medicine* for January, which will be issued next week, are as follows: Introduction; William H. Welch and Simon Flexner, Observations Concerning the Bacillus Aerogenes Capsulatus; W. T. Porter, Further Researches on the Closure of the Coronary Arteries; T. E. Shields, The Effect of Odors, Irritant Vapors, and Mental Work upon the Blood Flow, Plates I-VII; Ludwig Hektoen, The Vascular Changes of Tuberculous Meningitis, especially the Tuberculous Endarteritis, Plate VIII; W. H. Park and A. W. Williams, The Production of Diphtheria Toxine; R. H. Chittenden and William J. Gies, The Mucin of White Fibrous Connective Tissue; Arthur R. Cushny, On the Action of Piperidine and some of its Compounds. The *Journal* will not be issued at stated intervals, but as material is collected, and not less than four numbers will appear within the year.

## WASHINGTON NOTES.

A FALL of twenty per cent. occurred in the death rate of the city since the last report. The number of deaths reported at the Health Department was 110, making a decline in the annual death rate from 27.6 to 20.8. The mortality from lung diseases amounted to 20 as compared with 56 as by the last report. There were fewer cases of death from pneumonia and consumption. There were sixteen cases of diphtheria with three deaths and ten cases of scarlet fever with no deaths therefrom reported. There were two deaths from measles and two from gripe.

The Clinico-Pathological Society held its regular meeting on Tuesday evening, January 20, the President, Dr. H. B. Deale, in the chair. Dr. R. M. Ellyson read the paper of the evening, entitled Two Cases of Pleurisy with Effusion. A number of the members joined in the discussion.

The regular meeting of the Medical Society of the District of Columbia was held on Wednesday, January 22, the President, Dr. S. C. Busey, in the chair. The Committee on Public Health rendered their report on Typhoid Fever, Malarial Diseases, Smallpox, etc., in 1895. Dr. McCormick read a paper on Gelatine Dressings in Skin Diseases; giving demonstrations. Dr. J. W. Bovée reported a case of fibroid tumor complicating labor; removal. Uterine fibroids and pyo-salpinx; cases and specimens.

The Medical Society held a special meeting on January 22, at 2 o'clock, to take action in relation to the death of one of its members, Dr. W. E. Wolhaupter, a young man of great promise, son of Dr. and Mrs. D. P. Wolhaupter of this city. Proper resolutions were drawn up expressing sympathy and sorrow at the sad event.

The friction between the medical and lay directors of the Columbia Hospital is the subject of much talk in medical circles. On account of the opposition of the attending staff to infringement on their rights, Dr. J. F. Scott, obstetrician to the hospital, was not re-elected and in consequence Dr. A. F. A. King, also obstetrician to the hospital, immediately resigned and everyone is commanding him for his action. Dr. John F. Moran and Dr. H. D. Fry were elected in their places. It is thought that other resignations will soon follow.

## Book Reviews.

TENTH REPORT OF THE LUNACY COMMISSION OF MARYLAND. William Lee, M. D., Secretary. 1895.

In this report it is shown that all the asylums in Maryland except the Sheppard Asylum are crowded beyond measure. There are 3136 insane in the State. The delay in erecting the new hospital is deplored. There has been a generally improved condition of the insane due to better scientific work and good nursing. The Lunacy Commission desires a certain degree of conservatism in sexual operations on the insane in hospitals and advises the superintendents to consult with specialists before undertaking radical operations.

The necessity for a reformatory is pointed out again. The criminal insane should be separated from the innocent insane. Magistrates should not have the power of committing unfortunate weaklings. Insanity seems to be on the increase. Newspaper publicity increases the suicidal cases. Hypnotism, which is characterized as a disreputable form of charlatanry, is said to stimulate temporary insanity and public exhibitions of hypnotism should be suppressed by law.

THE DISEASES OF CHILDREN, MEDICAL AND SURGICAL. By Henry Ashby, M.D., Lond., F. R. C. P., Physician to the General Hospital for Sick Children, Manchester, etc., and G. A. Wright, B. A., M. B., Oxon., F.R.C.S., Eng., Assistant Surgeon to the Manchester Royal Infirmary and Surgeon to the Children's Hospital, etc. Third edition. Edited for American Students by William Perry Northrup, A. M., M. D., Adjunct Professor of the Diseases of Children, Bellevue Hospital Medical College, etc. New York: Longmans, Green & Co. London and Bombay. 1896.

A closely printed small octavo volume of 840 pages, with 200 illustrations. It is at the same time a text-book, a cyclopedia and an epitome of diseases of children in both their medical and their surgical aspects. A very satisfactory book for the practitioner and up-to-date. The authors very properly begin with the fetus, not at birth. They have the advantage of unusually extensive hospital experience and of well kept records in great children's hospitals of England and America.

The description of diseases is well given and their treatment is carefully considered, economy of space being secured by the omission of unnecessary discussions in phases of

each subject not of immediate practical value. The publishers' work is excellent. The print is clear but rather small for quick, easy reading. It is perhaps not a disadvantage to Americans to have a work by prominent English pediatricians, especially since the formulae of treatment are given in American terms. In one or two minor points the authors are not up to the latest American advances, but on the whole it is one of the neatest, handiest, most comprehensive works recently published.

**THE HYGIENIC AND MEDICAL TREATMENT OF CHILDREN.** By Thomas M. Roth, M. D., Professor Diseases of Children, Harvard University. Illustrated. Philadelphia: J. B. Lippincot Co. 1896.

A very handsome large octavo volume of 1124 pages. In some respects it is quite encyclopedic. The subjects are brought well up to date. The book is the work of a deeply scientific observer of enormous experience and of extensive research in the more newly developed departments of pediatrics. It is destined to have very great favor among practitioners of standing who desire to keep up with modern progress. Some slight faults might be found. A text-book should give more space to the discussion of different methods of treatment in each disease. The case records abundantly introduced are strangely bare of therapeutic notes. It is too much the fashion nowadays for writers to expatiate at length on pathology and other somewhat unpractical departments of medicine and to dismiss "treatment" with the scantiest possible notice. This leaves the young practitioner wholly without guidance in cases a little out of the usual run or peculiarly obstinate to treatment. If the reader fails to find typhoid fever in the index he may obtain a very unsatisfactory notice of it under ileo-colitis. Apparently it is little known in Harvard. The publishers' work seems to be beyond criticism. The book is a delightful one to read. The illustrations, colored, uncolored, photographic, are very numerous, beautifully executed and very instructive. Strange to say, the photographs are usually clear enough to throw light upon the associated text. The author has strangely omitted to include his own features in the photographs. Those who have read the illustrated articles by hospital workers of late will be astonished at the modesty here displayed.

## Current Editorial Comment.

### ANTITOXINE IN DIPHTHERIA.

*American Medico-Surgical Bulletin.*

FINALLY, while the percentage of mortality in diphtheria, as compared with the total number of cases reported, has been appreciably diminished, it is still doubtful whether the percentage of the community succumbing to this malady has been reduced or increased.

### PLEURISY AND TUBERCULOSIS.

*University Medical Magazine.*

THE relation existing between pleurisy and tuberculosis has for a long time attracted considerable attention. It is observed that pleurisy frequently follows fully-established phthisis, and that phthisis in many instances develops after an apparently cured pleurisy. Of ninety cases of acute pleurisy treated by Henry Bowditch of Boston, between 1849 and 1879, thirty-two died of or had phthisis. These clinical observations are confirmed by post-mortem records.

### MILK.

*Pacific Medical Journal.*

THE more we study the subject of milk as food for infants and young children the more we are impressed with enormous difficulties attending its production and delivery, pure and unadulterated, to consumers. That it shall be free from admixture with water and other deleterious substances is but one of the elements in the problem. The milk, though delivered to consumers just as it comes from the cows, may nevertheless contain enough micro-organisms to cause disease and even the death of infants drinking it.

### RECKLESS OPERATING.

*St. Louis Clinique.*

MODERN surgery is fast running into the extreme of interference with normal, structural and functional arrangements. The veriest tyro in medicine does not hesitate to plunge into the peritoneal cavity, take out an ovary or a kidney with the nonchalance of an epicure at his breakfast. But it will be said, "Are we not accomplishing wonderful results?" We are compelled to answer that we are, but one-half of these "wonderful results," and we speak very conservatively in saying one-half, never comes to the front.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### EMPYEMA.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
DECEMBER 3, 1895.

By John Van Rensselaer, M. D.,  
Washington, D. C.

EMPYEMA is a disease of not very infrequent occurrence, especially in childhood, the vast majority of cases being in children and young adults. As the term implies, it is a suppurative pleuritis whose development is often insidious and whose effect upon the patient's future health may be permanent.

It is not my intention to discuss this affection in its entirety, but to refer more especially to its cause and various methods of treatment. In this lesion, as in many others, recent bacteriological research has furnished a much clearer and more exact knowledge of its pathology than existed not a great many years ago. Formerly, it was thought the pleurae became infected either before or after a serous effusion had taken place, and that the membranes then underwent a purulent inflammation, but why this should be the case was beyond scientific explanation of the time. More recently, it has been held by pathologists that all pleurisies are of tubercular origin, but today we know there are several micro-organisms which may infect the pleural cavity in a variety of ways, and it is upon this knowledge that logical ideas of treatment are based and hopes of a speedy and permanent restoration to health entertained.

In this disease, as in others, the streptococcus pyogenes may give rise to an inflammation which is more virulent in its acuteness and far-reaching in its effects than that produced by a germ whose power of infection is milder; and so it may be said there are different varieties of empyema based upon the specific causative agents.

In children the pneumococcus is the most frequent micro-organism found, having gained entrance into the cavity by way of the lungs, and just as the presence of the diplococcus is often detected in expectoration where there is no existing pneumonia, so there may be empyema without pneumonia; in other words, the germs seem to have infected a more susceptible pleura rather than the lung tissue itself. This form of the disease is the most amenable to treatment, with a diagnosis correspondingly bright.

Why this micro-organism should produce empyema in some instances and not in others is unknown, but it is a fact that it may be found in a serous exudate which remains free from purulence. Whether there may be another infective agent present it is impossible to say; though none has been found, this is the probable explanation. An-

other reason may be that under certain conditions the forces of resistance of the tissues to the infective properties of the pneumococcus may be more effectual than in others.

A second variety is that of tubercular origin. Here again is a germ that may be present in a serous exudate without causing suppuration, yet it is a positive fact that Koch's bacillus may produce pus unaided by any other agent.

There is a third variety produced by any one or a number of the so-called pus organisms, most prominently the streptococcus and staphylococcus, and this naturally is the most dangerous and virulent of all. Occurring as it does as a complication or a sequela of the acute infectious diseases, typhoid fever, scarlatina and measles, at a time when the vital forces are at their lowest ebb and least able to withstand the inroads of another illness, its advent is frequently a forerunner of a fatal termination.

These varieties existing, the question of diagnosis in any given case, if not established by the history of the disease with its accompanying symptoms, can be definitely determined by an exploratory puncture of the cavity, and this being a most important and valuable procedure, a word may be devoted to it.

There is need of sterilization both of the chest wall and apparatus; the latter consisting of an ordinary hypodermic syringe in good working order, with a needle long and stout. The spot selected for examination should be that where later a radical operation may be done, that is, in the sixth or seventh intercostal space, immediately in front of the posterior axillary line. The needle should penetrate at least an inch, no harm resulting even if lung or liver be punctured if the needle be aseptic.

I do not believe an ordinary hypodermic needle is the proper instrument for this purpose, as the pleura becomes immensely thickened, taking on the consistency of leather in a very few days and being covered with lymph, while the exterior costal wall may also be edematous and swollen. Aside from this there are often lumps of flocculent matter floating in the pus, which become-

ing adherent to the sides of the cavity, thereby increase its thickness. If now a needle of the usual length and lumen should encounter a condition such as this, nothing would be gained.

If no pus is discovered upon one aspiration, others should be made at different levels to prevent the possibility of encapsulated or sacculated collections escaping notice; and if the progress of a case is not satisfactory, puncturing on consecutive days is to be advised. In a suspected case it might be well to fill the syringe with sterilized water, to be discharged when the needle has penetrated to its full extent, in this way being certain of clearing the immediate vicinity of its point from obstruction.

Exploratory puncture is a simple matter, but like many other simple procedures should be performed with care, thoroughness and with a clear understanding of what the pathological conditions present may be, so that in the event of no pus being found, a positive conclusion may be drawn that there is none in the cavity. Having thus established or confirmed the diagnosis of empyema, the value of a bacteriological examination of the material withdrawn becomes immediately apparent. In pneumococcus empyema the pus is thick and creamy, the disease is acute, and there is a tendency to perforation of the lung and evacuation through a portion. Tuberculous empyema is of a more latent character, slow in formation, its pus being thin and often flocculated.

Empyema due to specific pus organisms may be either acute or latent, more frequently the former, with grave symptoms, subsequent to the infectious forces or some other pyogenic lesion.

These disturbances are positively determined by microscopical examination affording a means of forming an accurate prognosis and pursuing common-sense treatment.

The prognosis is more favorable in children than adults, in recent than in old cases. In long-standing empyema the lung loses its normal force of expansion from the compression which it undergoes, and from numerous firm adhesions. In children, retraction of the

yielding chest wall enables the pleural cavity to close over a lung whose partial expansion has been destroyed in adults, a cavity remains which may never be obliterated. Pulmonary tuberculosis complicated by empyema constitutes a contra-indication to radical operation.

*Treatment:*—An abscess of the pleural cavity should be treated as is an accumulation of pus in any other part of the body; any considerable collection of pus is never absorbed. Treatment should be daily and is entirely surgical. The recognized operative procedures are aspiration, incision and drainage and resection of the rib.

In exceptional instances, aspiration alone has effected a cure in children more often than in adults, but it is also in children that the best results have been obtained from the radical operation, that is, incision of the pleural cavity and drainage by means of a rubber tube. Aspiration needs to be performed with the utmost regard for asepsis. Aspiration of a sterile serous effusion has been followed too often by subsequent pus formation to avoid the inference that careless manipulation has been the cause of the infection.

The question has many times arisen in my mind why the peritoneal cavity can be tapped almost with impunity in ascites and yet so much can be necessary in thoracentesis. I have been unable to discover any literature upon this subject. It must be due to the ability of the peritoneum to more readily absorb and quickly remove deleterious products. In constitutional affections having a tendency to serous effusions which are entirely free from the presence of bacteria, as chronic nephritis, malignant disease and anemia, aspiration of the pleural cavity must still be done with the utmost care to prevent infection, while the peritoneum may be invaded with an ordinary trocar and cannula, not overclean, and no harm follows.

Aspiration of the pleural cavity is best done with a Dieulafoy's instrument or one of its modifications, with a rather large needle, in the sixth or seventh intercostal space. Everything in connection with the operation should be sterile,

both the chest wall and apparatus. In passing, it is needless to speak of the importance of avoiding mixed infection, for empyemas which would probably yield readily to treatment are often given a most intractable character by the introduction of putrefactive bacteria of a virulent type from without, thus perhaps changing a pneumococcus empyema with a tendency to speedy cure on evacuation of the abscess to one whose most marked clinical feature is an ability to secrete unlimited amounts of pus which may never be cured. It is a good plan in every case to combine aspiration with exploration, thus relieving a bad state of affairs as soon as discovered and bringing the parts into a condition for radical operation. The longer the lung is compressed by fluid and the fibrous adhesions are acquiring strength, the less likelihood of restoring the cavity to its normal condition.

The constitutional effect upon the patient should be closely watched during the withdrawal of fluid to detect signs of faintness or untoward results from displacement of the organs as they return to their normal positions; dyspnea, giddiness or irregularity of pulse should be the signals for promptly suspending operations, beginning anew as soon as unpleasant, not to say dangerous, manifestations have subsided. Little is to be gained by aspiration alone, as it is but a stepping-stone to other measures and might entirely be dispensed with were it not that the pneumococcus empyema of children is sometimes cured by it. Aspiration does not drain sufficiently nor does it remove the masses of flocculent lymph which may be in the cavity.

Incision and drainage are the ideal treatment, the formation at the most dependent point of an exit for inflammatory products, which is maintained patulous until no longer needed. The operation should be aseptic as far as possible. The skin over the seat of operation having been raised or slid upward, and held tense, an incision down to the bone is made over the seventh or eighth rib; the periosteum having been stripped back for an inch on all sides, the blade

of a bone forceps is passed between periosteum and bone, and an inch of it is resected ; through an incision in the pleura, a tube of large caliber is inserted and the pus permitted to make a slow exit. This tube should be secured either by suture or large pin to prevent its being drawn into the cavity, an accident which has happened more than once. In children, where the ribs are more elastic and the relative distance between them greater, it may be unnecessary to excise a portion of it, for the reason that a large tube can be admitted.

Some surgeons advise against resection in adults because they consider it unnecessary, but this is not universally conceded and in all the cases I have seen treated in this manner the results have been unsatisfactory ; drainage cannot be thoroughly established unless the tube be of good size. Another decided advantage of rib resection is the ability to introduce the finger, palpate the floor of the cavity, scrape away any lymph or flocculent matter and determine perhaps the amount of lung expansion or compression. Unless there be fetor or very thick discharge, irrigation is unnecessary and harmful. Dressings should be applied as after a sterile operation with the addition of more absorbent material than usual, as the discharge will be copious. At the removal of each dressing, care must still be taken to preserve the bland nature of the pus.

In the course of not many days the discharge will have become so scanty as to indicate that it is maintained by the irritation of the tube, which may then be removed with an entire closure of the wound in a short time. This is the course of events in favorable cases. In others, there will be no decrease but rather more pus is formed, with a fetid odor, and unhealthy color, positive indications of infection by putrefactive germs. Irrigation with weak antiseptic solutions may then be instituted, and continued for months, only to be succeeded by the most radical operation, thoractomy, or resection of several ribs, with a view of allowing the chest wall to recede and obliterate the cavity by contact with lung tissue. Unfortunately

this sometimes fails and the patient's condition is very wretched.

I have in mind now a man in New York, whose habit it was to visit the different dispensaries for dressing, taking each in turn and remaining until the patience of those in attendance became exhausted, when he went on to the next. He had been operated upon by a skilful surgeon in the endeavor to cure his malady, but the result was a cavity fully large enough to contain an infant's head, in which could be seen the unexpanded lung on the inner and upper wall, covered with thick lymph and with an exterior opening sufficiently large to admit an orange ; in this case, the ribs had failed to retract. If by exercising skill and care in early stages of this disease, such a state of affairs can be prevented, it certainly ought to be done. Notwithstanding precaution, empyemas will do badly, as the following case will show :

A. W. white, aged 20 years, the daughter of strong, sturdy parents, had always lived in the country and never been ill. On March 1, 1894, while visiting in town, she was exposed in a chilly rain, reaching home very wet, and on the following day complained of a sharp pain in left side of the chest of great severity, to relieve which Dr. Suter was called in attendance. This proved to be the insufficiency of a left pleurisy with effusion.

March 10, symptoms of compression with dyspnea well marked and I was called to aspirate, which I did as aseptically as possible, withdrawing forty-five ounces of serum, which was not examined.

March 17. Again there were signs of compression and thirty ounces of pus were withdrawn.

March 19. Under ether anesthesia, incision was made and drainage tube inserted.

April 19. Much pus. The dressings had been done as carefully as possible to avoid fresh infection. At this time was commenced irrigation with warm boric acid solution and later with twenty-five per cent. hydrogen peroxide.

May 19. The discharge having now become much diminished, the tube was removed and she returned home with a

fistula. During the past year she has been seen occasionally, and at each visit there has been an increase of pus of an offensive odor, notwithstanding which her general health has been excellent, her weight has increased, her color is bright, and she would be considered by any one unfamiliar with her condition as a buxom country lass. The chest is resonant in front as low as the sixth rib, but posteriorly there is dulness from the spine of the scapula downwards.

A further operation having been advised, it was performed November 25, 1895, one week ago. Under ether anesthesia, I made an incision in mid-axilla from the third to seventh rib, excising portions of the intervening bones and incising pleura. The lung seemed to expand fairly well, though it did not

entirely fill the cavity, while the pleura was rough and very thick.

I found then what appeared to be a large sinus running back following the chest wall as far as I could pass a probe, which was curetted gently but thoroughly, irrigated and a large tube inserted. The rib at the mouth of the fistula had undergone eburnation and was removed with great difficulty.

For two days after the operation, there was a chronic discharge of bloody serum which gradually became less, until now it is quite scanty. The dulness posteriorly I attribute to the very thick pleura.

January 15, 1896. The patient is quite well, the wound in the chest having closed completely more than a month ago, shortly after the removal of the tube.

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**A NEW FORM OF ANASTOMOTIC BUTTON.**—Chapot (*British Medical Journal*) has lately brought before the Société de Chirurgie de Paris a new anastomotic button for operations on the intestine. The advantages of this, it is stated, depend on the flexibility of the metal employed, which is pure tin. The general form of the button is that of an elliptiform ring, pierced in its center by an oval orifice. When seen in profile it presents a circular groove, measuring nearly half an inch in width and a third of an inch in depth. The lips of this groove present three clefts on either side. The intervening portions of metal are thin enough to be readily moved inwards or outwards by the pressure of the fingers, the width of the groove being thus diminished or enlarged. In performing an entero-anastomosis Chaput makes in each loop of gut a longitudinal incision of sufficient length for the admission of the button. The margins of each intestinal wound are fixed in the groove by a running suture, applied as in the use of Murphy's button. The lips of the groove are now pressed together by the fingers applied to the outside of the intestine. This approximation of the lips of the groove gives the same result as a row of sutures,

for the thin layers of tin when brought together cannot be separated without difficulty. As a further precaution, however, the author surrounds the button with sutures carried through the apposed serous coats at intervals of about half an inch. This button can be used also in cases of circular suture of the intestine. Three cases are recorded in which this form of button has been tried. In the first, which was one of gastro-enterostomy for pyloric stenosis, which proved fatal from exhaustion on the tenth day, the anastomosis was found to be absolutely intact.

The second case was one of obstructive cancer of the transverse colon. The button came away from the rectum on the tenth day, and in a second laparotomy, indicated by symptoms of intestinal paralysis, the author was enabled to make out complete integrity of the anastomosis. In the third case both gastro-enterostomy and entero-anastomosis were performed at the same operation on a patient suffering from cancer of the stomach. This patient was in a perfect state of health two months and a half from the date of operation, but during this interval had not passed either of the buttons.

## A DIFFICULT CRANIOTOMY, WITH SOME SUGGESTIONS.

By Harry H. Arthur, M. D.,

Formerly Resident Physician to the Free Lying-in Hospital of the University of Maryland.

IN reporting the following, it is not my object to enter into a recital of the various steps in the technique of the operation of craniotomy, but to present as briefly as possible a review of a case, its several complications, and the adverse circumstances under which delivery was accomplished.

The patient was a multipara, who a year or more previously had been delivered, after considerable difficulty, of a premature child. At the same time she had been warned that a second pregnancy would be attended by a repetition of operative procedures more severe than the first, if not by fatal result, as her pelvic deformity was so marked as to render delivery by ordinary means, such as forceps, impracticable. That the injunction was unheeded is only too obvious.

Labor began early in the morning of August 8, 1895, and progressed until full dilatation of the os was completed. A vertex presentation was diagnosed although the head had not yet become engaged. About four o'clock P. M., after recognizing the obstacle to normal delivery, her attending physician, with the assistance of a neighboring practitioner, applied forceps.

Their efforts in this direction were rewarded by the slipping of the blades, which were repeatedly readjusted and traction again made, only to meet with the same result, the engagement and descent of the head not having been influenced in the least.

After having apparently exhausted their resources, as well as themselves, in many unsuccessful attempts to terminate the labor, I was called in consultation.

As the house was some distance in Howard County, I did not arrive until 12 o'clock midnight. Upon vaginal examination the pelvis was found to be contracted antero-posteriorly, the conjugata vera measuring about 7.5 c.m. (or 3

inches); also, in addition to this, was an exaggerated sacral promontory, on the right lateral aspect of which was what seemed to be a slight projection, the exact nature of which I was unable to determine, probaly an exostosis.

Fetal life had become extinct during the afternoon. I applied the Tarnier axis traction forceps, but on making traction, they too promptly slipped off, the fetal head not presenting the proper diameter for application and retention of the blades. Even had I secured this, as I afterwards found, I could not have accomplished delivery, so after a second unsuccessful trial, I abandoned the procedure.

To have accomplished delivery by version would have been a physical impossibility, as the uterus was very tetanic, ergot having been given previous to my arrival; also any attempt to turn the fetus under such conditions would have been accompanied by immediate risk of rupture of the uterus, the lower segment of which had already become appreciably thinned. Even in event of successful version, the after-coming head would have required either crushing or craniotomy, or both, which would have been rather difficult, and hence comparatively undesirable to craniotomy in a vertex presentation. Obviously, the conditions under which the operation was undertaken and delivery effected *i. e.*, pelvic contraction, progressing maternal exhaustion, and a dead fetus, rendered craniotomy not only justifiable, but necessary.

In perforating I used the Smellie scissors, entering the points just anterior to the posterior fontanelle. After securing a sufficient opening, I removed the brain, and applied the ordinary forceps to compress the head, but the disproportion between it and the pelvis was so great that efforts at extraction by this method proved futile. Not having cra-

niotomy forceps, I then, with my fingers, broke up both parietal and part of the occipital bone, piecemeal, all the while protecting the maternal parts from contact with the fragments of bone.

The frontal bone was then bent back over the sharp projecting edges of the base of the skull, thus preventing laceration of the vagina during descent. I then inserted a blunt hook, under the mental symphysis, and with the assistance of supra-pubic pressure, made traction, bringing the remains of the head just to the vaginal orifice, when another impediment was encountered, and upon examination I found that the shoulders had not entered the superior strait. I tried to pull them into the pelvis with a blunt hook under the shoulders, but without avail. The remains of the head were removed in the vagina, and the shoulders pushed back from the pelvic brim, after which I turned the fetus and thus effected delivery.

Incidentally I would remark that the patient just before delivery showed signs of collapse, but after necessary stimulation, rallied sufficiently to permit a resumption of the operation. The uterus was douched with 1-6000 solution bichloride of mercury. Ergotole twenty minims was given hypodermically.

The amount of hemorrhage, both ante- and post-partum, was comparatively small. The patient emerged from anesthesia in fair condition, her cheeks maintaining their former rosy color. A day or two later, I was informed by her attending physician that she died at ten o'clock in the morning, seven hours after the operation, not before all efforts to revive her had been exhausted.

It is probable that while death may have been partly due to shock, it was more directly the result of the prolonged anesthesia, the patient having been more or less under chloroform for about four hours previous to my arrival, and then for the three consecutive hours required for the operation.

In making a few comments regarding such cases it is not my purpose to refer to the different forms of contracted pelvis, nor to the special indications for op-

erations, but rather to urge the necessity of examination, previous to labor, of all pelvis, especially primiparous. Where pelvic deformity is either suggested or apparent, as in rachitis, scoliosis, lordosis, kyphosis, etc., it is to be presumed that special attention would at once be directed.

No conscientious obstetrician fails to make a thorough urinary analysis in every case of pregnancy under his care, so that in event of the discovery of albumen or casts, or both, he may institute proper prophylactic measures to avert the occurrence of eclampsia. It is one of his first duties to the mother as well as to her unborn child, failure in the performance of which renders him guilty of culpable neglect.

While contracted pelvis is not so frequently met with as eclampsia, still his obligations demand careful observation, and pelvic examination, and the obstetrician or general practitioner has not discharged his preliminary responsibilities until such have been accomplished. Of course, in the case of a multipara who has given birth to one full-term child, either normally or with aid of forceps, such preliminary pelvimetry would probably be unnecessary. It is, however, to primiparae generally, whether physical deformity be evident or not, that the above precaution applies.

The case just cited is one in point, in that external appearances indicated a normal pelvis. This is especially true in symmetrically or generally contracted pelvis. With reference to the time at which such examination should be made (I refer now especially to those cases where there is no indication of deformity), it would be well to note that the uterus ascends in the abdominal cavity until about the thirty-eighth week (the second week before the completion of the pregnancy), at which time it begins to descend and sink into the pelvis, thus undergoing what is commonly termed "lightening."

Simultaneously with this process, the fetal head, in vertex presentations, assumes certain relations to the pelvis; thus in case of a multipara, by reason of the relaxed abdominal wall, the fetal

axis is not coincident with, but forms an angle with the axis of the superior strait, which position is maintained until labor occurs, hence there is no engagement of the head until that time. On the other hand, in the primipara, when the uterus descends, the abdominal walls being very tense, operate to place the fetal axis in coincidence with the axis of the superior strait, thus, under normal conditions, causing the head to enter and gradually become engaged in the pelvis.

Therefore, if in the primiparous case such engagement fails to occur, it might be attributable to such causes as (1) abnormality of the fetus, *e. g.*, monstrosity, hydrocephalus. (2) Hydramnion, a factor which, as I have had occasion to note, was operative in several cases. (3) Contracted pelvis, etc.

Ordinarily, vaginal examination in a multipara is not called for, but in first pregnancies, when this is omitted, should you on palpation at the time just indicated find non-engagement of the head, or again, when digital examination of the vagina, uterus, etc., in the early months has enabled you to detect pelvic contraction, it becomes imperative to adopt such measures as will enable you to estimate the dimensions externally, the conjugate diameters, the importance of exostosis, etc., as constituting further obstacles to delivery.

Thus only can intelligent treatment be instituted to meet the conditions of any particular case. Again, if on palpation you should diagnose a presentation of the breech, lateral plane, etc., the same precautions should be observed. Only while resident physician at the Lying-in Hospital was I called upon by the students in charge of a case to deliver a woman whose pelvis was slightly flattened antero-posteriorly. I found a lateral plane presentation, with an arm extended into the vagina. I turned the fetus, made several attempts to deliver the after-coming head and, finally, as the child was dead, delivery was effected by manual compression.

Regarding operative interference, it must vary according to the nature of contraction, briefly in a pelvis flat-

tened antero-posteriorly with a true conjugate of 8.1 to 9 c. m. ( $3\frac{1}{4}$  to  $3\frac{1}{2}$  inches) and a fetal head of ordinary dimensions, delivery can be accomplished by forceps or probably version; or again, where the true conjugate measures 6.5 to 7.5 c. m. ( $2\frac{1}{2}$  to 3 inches) it is a pelvis through which the average head will not pass and, therefore, should the child be living, symphysiotomy is indicated or, in the event of its death, craniotomy.

In those forms of contracted pelvis where the true conjugate is less than 6.5 c. m. ( $2\frac{1}{2}$  inches), either with or without osseous encroachment or, again, where the true conjugate is sufficient for passage of the head under symphysiotomy and yet complicated by an exostosis; or further, when the pelvis is so distorted as to render symphysiotomy ineligible, Cesarean section is demanded.

I have purposely omitted mention of the induction of premature labor in the treatment of these cases, as it is to a great extent being superseded by symphysiotomy. As to the advantages of either operation, without going into a comparative analysis, I would refer you to the statistics, which show as results of the induction of premature labor, a fetal mortality of a little more than 60 per cent., which, of course, includes those deaths occurring during delivery and those occurring afterward, due to prematurity. On the other hand, symphysiotomy holds out a much greater chance to the child, as under this operation the fetal mortality is very small, ranging from 5 to 10 per cent., which estimate is based on the results of operations performed both in this country and in Europe.

Regarding maternal mortality, the results are about equal, the percentage being comparatively small under either. Hence, as the operation is done largely, if not entirely, in the interest of the child, symphysiotomy will undoubtedly take precedence over the induction of premature labor. In conclusion, while craniotomy on the dead fetus is repulsive, it is not only more so on the living and but rarely ever justifiable, even though the case is seen in an emergency and for the first time, unless the condi-

tions are such that the mother's life depends on the sacrifice of the fetus.

Therefore, on the whole, if pelvic examination be made at the proper time, we can, by the exercise of such means as

are at our command, avert many unhappy consequences and secure a successful termination in the salvation of both mother and child, a thing which is plainly our duty.

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## A CASE OF VICARIOUS MENSTRUATION MANIFESTED BY HEMETEMESIS.

By *W. Milton Lewis, M. D.,*

Baltimore.

THE patient, F. P., a girl 23 years of age, single, presented herself at the Baltimore Eye, Ear and Throat Hospital in April, 1890, for relief from a phlyctenular conjunctivitis and divergent strabismus of the left eye.

Her clinical history, as recorded at that time, was to the effect that her illness dated from her third year, at which time she had an "erysipelas," which affection was, in the light of subsequent developments, most probably a pustular eczema, beginning upon the left foot and later extending over the entire body. Her family history is as follows: Both parents living and in good health; four brothers living, well; one dead, cause not known. Four sisters living, well, except one, who has coxalgia, the leg being 4 cm. shorter than its fellow. One sister died in infancy; cause, trismus neonatorum.

Her first menstruation appeared during the winter of 1890-91, at which time she was 19 years of age. Since this period her menses have been very irregular, often being suppressed for months and, once, an entire year, at a time. She has had a variety of diseases, among which may be mentioned several attacks of hysterical paralysis and hysterical contracture affecting the muscles of the arms and legs, headache, vomiting, epistaxis, hemoptysis, hematemesis, furuncles, constipation, pains in various regions, particularly in the left iliac fossa, etc.

She was treated in the Hospital of the Good Samaritan during last winter for a hysterical club-foot, by means of a plas-

ter of Paris bandage and hypnotic suggestion, but with negative result.

She next had a severe attack of eczema, which spread over the face, chest, portions of the abdomen, and the upper and lower extremities, only the back, apparently, being left free. It was pustular in character, and stubbornly resisted every effort made to control it by means of drugs.

A number of the pustules became veritable furuncles and had to be incised. These operations were performed under an anesthesia induced by hypnotic suggestion, one by Dr. Forsythe, and one by Dr. Jay, with entire success.

As about this time she complained most of her abdominal pains, she was examined by Dr. Browne and by Dr. Clark of the Hopkins. Dr. Browne's report was not favorable to an operation; Dr. Clark advised against an operation, stating that the adnexa were perfectly normal. Dr. Clark's examination was made under ether. She was also examined by Dr. H. A. Kelly, with a similar result.

As she now began to complain of dyspeptic symptoms, she was ordered an Ewald's test-breakfast, and her gastric juice removed for examination.

In this case, notwithstanding the use of a Boas tube, it was found, after several trials made on different days, to be impossible to secure a specimen of the gastric juice. She was then given a test-meal in the office, and forty-five minutes later, about 50 c.c. of perfectly normal gastric juice was without difficulty obtained. Total acidity, 40.078, corres-

ponding to 1.5 per cent. free hydrochloric acid. No lactic acid. Abdominal examinations, repeatedly made, showed nothing abnormal.

During the period of nearly five years since the first appearance of the menses, she has probably not menstruated more than twenty times. In August just passed, she had an attack of vomiting of blood which, during the succeeding days, was several times repeated. The color of the blood ejected during the earlier seizures was dark, while later on it became of a light red. At the same time she suffered with pain in the epigastrium which was, however, not made worse by the taking of food.

Her condition on October 11, 1895, was as follows: Patient rather under size, looks younger than she is, of slight build, brown eyes, light-brown hair, conjunctiva and ears pale, musculature poor, tongue good color, not furred, pulse 80, small in volume, fingers cold, and skin moist. Lungs clear on percussion and auscultation both in front and behind. Heart's dulness within normal limits, apex clear, soft blowing systolic murmur at the base, not heard at the apex. Sound clear at the aortic cartilage.

In the abdomen tenderness less marked over the right than the left abdominal zone and is particularly pronounced in the epigastric and left iliac regions. Kidneys, liver and spleen are not palpable. No splashing sounds are audible for five hours after a meal consisting of crackers and chocolate. After ingestion of 125 c.c. of water, very evident splashing sounds were elicited with ease above and to the left of the navel.

The greater curvature of the stomach could be made out by percussion at the lower margin of the navel. After 250 c.c. had been taken, the splashing sounds were easily recognized to the left, above, to the right, and at the navel. Percussion showed the greater curvature to extend 1.25 to 1.5 cm. below the navel, when the patient occupied the recumbent position, while in the erect posture it extended from 3.5 to 4 cm. below. After having assumed the erect posture it was found that splashing sounds were

only made out on deep succussion. No glandular enlargements are to be found. The patellar reflex somewhat exaggerated on both sides but there is no ankle clonus. The examination of the urine was negative.

There was some diminution in the number of red blood corpuscles present (less than 4,000,000), no hyperleucocytosis; a digestive leucocytosis of 10-12,000 was noted. Hb. was not estimated. After one of these attacks of hematemesis the stools were examined and found to contain blood. The reaction of the vomited matter, *i. e.*, blood, has been uniformly acid.

Dr. L. Kuttner publishes an interesting paper in the *Berliner Klinische Wochenschrift*, Nos. 7, 8, 9 of last year, in which he reports a number of cases in point, occurring in Ewald's clinic. His cases all occurred in chlorotic women of a decided neurasthenic tendency.

In the case which is here reported, the diagnosis wavers between gastric ulcer and vicarious menstruation. The epigastric pain, the somewhat irregular recurrence of the hemorrhage, it appearing at intervals of from one to three weeks, the presence of a practically normal amount of free hydrochloric acid, appearance of blood in the feces, a normal indican reaction, all speak for the diagnosis of gastric ulcer, while on the other hand, the marked amenorrhea, the fact that pressure was much better borne, when she did not have her attention drawn to the examination, that the taking of food did not materially affect the degree of pain, that her stomach motility was not impaired, lead to the theory of vicarious menstruation.

The proof of the actual presence of blood in the gastric contents in this case rests upon the fact that hemin crystals could be demonstrated with the microscope and that the sediment consisted largely of hematin in amorphous masses.

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**INFECTED HEIRLOOMS.**—An exchange calls attention to the infective dust in old tapestries and heirlooms. Do the bacteriologists wish us to sterilize all of our relics?

## Society Reports.

### THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.

MEETING HELD DECEMBER 31, 1895.

*Dr. John Van Rensselaer* read a paper on EMPYEMA (See page 289).

*Dr. Mackall* opened the discussion by saying that the paper of Dr. Van Rensselaer was a most thorough and scientific one. The etiology of empyema is divided by pathologists and bacteriologists into four classes. The first class caused by the pneumococcus represents 29 per cent. of all cases, and occurs most frequently in children, the second class of cases is caused by the streptococcus and represents 46 per cent. of all cases, occurring most frequently in adults; the third class of cases is caused by the staphylococcus and represents 13 per cent. of all cases; the fourth class is caused by the bacillus of tuberculosis and represents 11 per cent. of all cases.

In a summary of 389 cases by Bowditch, operation with irrigation of the cavity was done in only two cases, showing that irrigation was not deemed necessary. He remembered well a case of empyema that came under his father's care, from the hands of another reputable physician who had diagnosed it as one of pulmonary tuberculosis, and had given up the further treatment of it on account of the extremely unfavorable prognosis. His father diagnosed the case empyema and directed him to make an incision between the sixth and seventh ribs. A quantity of pus was discharged, a drainage tube was inserted and kept in the wound for some time, until recovery was complete.

*Dr. Glazebrook*, in connection with this subject of empyema, presented the specimen of a compressed lung, with the following history: Some three weeks ago a boy was kicked very severely by a man and after some time died. The autopsy showed the left side of the chest bulged and a large contusion still remaining. The heart was pushed over to the right, and when the pleural sac on the left side was punctured sero-purulent matter to the amount

of three pints spurted out. He found the lung on this side pushed up behind and fearfully compressed. The other lung was almost three times as large on account of having to do the work of two lungs.

In regard to operative procedure for empyema he would say that resection of the ribs is the measure to be used; as the ribs in adults are so close it is impossible to get opening enough to allow drainage. He does not see the use of resecting one rib, as the contraction cannot be sufficient to remedy much the condition present. In one severe case upon which he operated during his hospital service he did not douche out the cavity, but used a large and long drainage tube. Patient recovered.

*Dr. Ruffin* said the paper of the evening was a hard one to discuss, because the subject had been treated so thoroughly. One indication in the treatment of empyema that he had not heard discussed was to relieve the compression of the lung caused by this disease. After the incision has been made and the pleural cavity drained, an excellent opportunity presents itself for the use of lung gymnastics.

A device for this purpose used in the Johns Hopkins Hospital is made by connecting two glass jars by a rubber tube, and having a tube running from one jar to the mouth of the patient. This jar is filled with water, the other jar is empty. The amount of water forced from the filled jar to the empty one indicates the amount of force and distension of the lungs used by the patient. A great deal of expansion can be gained in this way. This helps in many ways and makes recovery rapid.

*Dr. Glazebrook* spoke of the frequency with which we find pleurisy with effusion, and the thickening that the pleura undergoes thereby.

*Dr. Snyder* had seen a few cases of empyema in his hospital work. One case occurring in an organ grinder was treated by an incision under cocaine, as the ribs had not fallen together, and the cavity was irrigated freely with a 50 per cent. solution of hydrogen peroxide, and a drainage tube inserted. Heavy

sweating followed this operation. In two days afterwards the irrigation was repeated and this operation was again followed by a heavy sweat. The patient recovered rapidly. Another case of empyema caused by tubercular disease was treated by an incision under cocaine, the insertion of a drainage tube and the making of a counter opening. A profuse discharge occurred, the cavity was irrigated with hydrogen peroxide solution of 50 per cent., but this operation was not followed by profuse sweating as in the former case. The discharge was so profuse in this case that it was conducted from the cavity to a vessel under the bed by a tube long enough for the purpose. The patient could inflate his lungs and drive the fluid out.

Exsecting one rib merely allows one place to fall in and causes a closing up of the sinus; if exsection is done more than one rib should be cut. Drs. Shrady and Keen take out large sections of the ribs from the second to the eighth ribs. A double opening does not complicate a case, a good, free opening helps a case, and he does not see why in Dr. Van Rensselaer's case a counter opening could not be made.

*Dr. Cole* had seen two cases of resection of the ribs in empyema during his hospital service; one recovered, the other died. The case of recovery was that of a white man, while the fatal case was that of a colored man. He has no doubt that more than one rib should be resected. One case in private practice was relieved by incision and drainage tube; it was an acute case following typhoid fever.

*Dr. Van Rensselaer*, in closing, said several members had spoken as if he had recommended resection of one rib. This was not his intention, as he believed that for curative purposes several ribs should be resected. In his case a counter opening was not made because he wished to avoid the necessity of making an opening through the ribs and scapula as his patient was very weak from the long illness.

He heartily approved of Dr. Ruffin's suggestion of lung gymnastics. Irrigation with hydrogen peroxide he thought

was a dangerous practice, as alarming symptoms have been caused by this operation which must be due to the absorption of the hydrogen. It seems strange that we can tap the peritoneal cavity with such impunity and it is so hazardous to tap the pleural cavity, unless it be that the pleura absorbs septic matter more rapidly and easily than the peritoneum.

R. T. HOLDEN, M. D., Secretary.

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### Medical Progress.

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LABOR AFTER VAGINO-FIXATION.—Wertheim, in an article entitled The Course of Labor and Pregnancy after Vagino-Fixation of the Uterus, in *Centralblatt für Gynäkologie*, 1896, No. 2, points out that the operation of stitching the fundus of the uterus to the anterior vaginal wall, as recommended by Dührssen and Mackenrodt for the cure of posterior displacements of the uterus, not infrequently gives rise to such serious complications during pregnancy and labor, that its employment should be limited entirely to women who have passed the child-bearing age.

In a case of labor, which he observed, following this operation, the adhesions between the anterior wall of the uterus and the bladder and vagina were so dense that they were not loosened at all during the course of pregnancy, and as a result, the anterior wall of the uterus could not expand during pregnancy, so that the entire increase in size occurred in its posterior wall. The immediate result of this was that the cervix, instead of occupying its normal position, was thrown upwards and backwards, and was above the level of the superior strait. This naturally interfered very seriously with the course of labor. The period of dilatation was very slow, and the delivery of the child could only be effected by introducing the whole hand into the vagina, when the cervix could only be reached with the greatest difficulty, and performing version by Braxton Hick's method through the slightly dilated cervix.

He refers to more or less similar cases

of Strassmann and Graefe, which followed the same operation, but which could not be terminated so readily as his case; for in both of them it was necessary to perform Cesarean section, on account of the very abnormal position of the cervix which was produced by the operation.

The consideration of these three cases naturally raises grave doubts as to the propriety of the operation, and has induced Wertheim, as well as Mackenrodt, its originator, to abandon it, and to warn the profession against it, except where the women have passed the menopause.

\* \* \*

**LOCAL PERITONITIS.**—Dr. Byron Robinson concludes an article in the *New York Medical Journal* on local peritonitis as follows :

1. The local peritonitis of adults is seldom directly fatal, but may produce a train of symptoms, such as indigestion, malnutrition, anemia and neurosis.

2. The peritoneal adhesions which demand operation belong almost exclusively to those involving the organs of high mobility and peristalsis, such as the small intestines, the sigmoid, the bladder and the Fallopian tubes (especially amputated ones).

3. Local peritonitis occurs at fixed bowel flexures and at the longest range of muscular action associated with the peritoneum.

4. The etiology of the adult local peritonitis is infectious invasion through the gut wall.

5. The methods of transmission of infection are through abrasion of the mucosa aided by the trauma of muscular action on a bowel containing pathogenic microbes.

6. Local peritonitis does not occur in infants at bowel flexures, or especially over the long range of muscular action.

7. It is extremely rare to see an adult with a normal peritoneum—*i. e.*, free from peritonitis.

8. The constant adhesions found around the gall bladder and ceco-appendicular apparatus teach us that operations in these regions can not be justified merely on account of the adhesions.

9. Adult local peritonitis seems to increase with age.

10. Peritonitic adhesions seem to be able to organize and appear and act like normal peritoneum.

11. Peritonitis is Nature's method of repair and prophylaxis. Peritonitis saves life, while infection kills.

12. Local peritonitis occurs chiefly on the dorsal region, at the points where the mesenteries fix the digestive tract and close to the highest range of muscular action. Muscular trauma, abraded epithelia and infection tell the tale.

13. The track of the infection from mucosa to serosa can not always be traced. A healthy mucosa (and even muscularis) may underlie many peritoneal adhesions, or a healthy serosa may be adjacent to diseased mucosa.

14. The dense adhesions of local peritonitis may result in strictures, malignancy, dislocated viscera, pain, restriction of peristalsis, and immobility of organs—disease.

15. The peritoneum may have its endothelium abraded traumatically by muscular action, and the resulting healing be cicatricial; the matter of local peritonitis being a slow, gradual, evolutionary process of adult life.

\* \* \*

**COMPETITION IN MEDICAL PRACTICE.**—The following extract, says the *Boston Medical and Surgical Journal*, from a private letter written by a young Boston physician under date of May 26, 1827, may be of possible interest to young doctors of the present day who are inclined to think that the competitions of medical practice are keener than ever before: “The profession does not offer even a prospect of support to a young man here; and if this plan (the establishment of a medical journal) fails, I believe I shall try some other employment. There is as much contest about a district of the Dispensary which Lewis is about giving up as if there was a salary of a thousand dollars to go with it. The fortunate applicant will perhaps find he has caught—a Tartar.” We are not informed whether this young physician made a fortune out of a medical journal or “tried some other employment.”

MARYLAND  
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BALTIMORE, FEBRUARY 8, 1896.

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THE periodical outcry against water pollution has recently been heard in this region.

The fear is that the *Health in Massachusetts and Maryland.* sources of the water supply of Baltimore

are not properly protected and that the drinking water is consequently polluted. For this purpose the bill, the text of which was published in the last issue, has been prepared as an attempt to guard against polluted water.

The measures of this bill are far reaching and have naturally aroused some opposition in the country bordering on the small tributaries of the water supply. The plan suggested, if carried out faithfully and efficiently throughout the year, in time of health as in time of disease, might protect the water, but it would involve an enormous expense, and it is a question, as these outlying districts become more thickly populated, how defilement can be prevented, unless the municipal

authorities condemn and buy all land for a distance bordering on all tributaries, which would cost too much for the taxpayers.

Massachusetts, which is one of the most densely populated States in the Union, has had this same problem to deal with and it is much nearer a solution that we are, should our proposed bill become a law and be enforced. Massachusetts contains 7800 square miles and 2,500,000 inhabitants, and has 39 cities of 10,000, 20 of 25,000, and more than three-fourths of the whole State live in cities of 7000 and over. The history of the difficulties which this State had to encounter in obtaining a pure water supply has been related at various times, and more recently in the *Forum* by Dr. W. T. Sedgwick, biologist to the Health Board. He gives a cursory history of the formation of the health board in that State and dwells particularly on the liberality and intelligence of the State Legislature, which gave them all the money asked for, this money being expended for scientific advice, works and the board itself serving without pay as in Maryland, so that from 1886 to 1895 the State Board of Health of that State spent over \$300,000.

The plan developed gradually and resulted in the Lawrence experiment station in 1887, the first of its kind in this country. First of all large tubs were obtained in which the various kinds of soil and sands were tested as to their purifying powers, until it was found that fine sand freed polluted water from its impurities, not only by filtration, but by oxidation when the filtering process was slow. The water was tested as it came out and one gauge was by the amount of salt it contained, the presence of salt indicating decomposition and impurity. The towns on the Merrimac river are so close together that one takes up its drinking water at a point very near where the one above it pours its sewage.

The intermittent filter beds have been described before. A flat tract of land is divided into squares and a bed is made of coarse, and on top fine, sand. The impure river water is led into these filter beds and by a combined sedimentation and filtration which must be very slow the water comes through pure and potable. The same filter bed is not used too often and is allowed to rest and be cleaned and each one is used intermittently. Maryland has an area of 9860 square miles, with a population of 1,042,390.

The State Board of Health is composed of intelligent men, but the niggardly appropriations stand in the way of making any scientific advances and even the laws now on the statute book cannot be enforced through lack of means for detection and prosecution. The apathy of the physicians of Maryland (and the same state of affairs may exist in other States) in regard to matters pertaining to health is deplorable. Aside from the political aspect of the question there are few physicians in Maryland who care who has charge of the health of the cities and State.

The comparative pay of law and medical officers, in Baltimore, for instance, shows the apparent value of each in the eyes of the people. The Health Commissioner of Baltimore receives a salary of \$2500 a year, is obliged to be on duty most of the day and in the case of our present conscientious health officer he is often on duty the whole day and when necessity demands it, in the night too, so that private practice is out of the question and if, for any cause, he loses his position he must commence practice anew as a young man.

The city solicitor, as the highest law officer, receives \$4000 a year, can and does attend to his private practice, and by virtue of his office and his familiarity with the laws he is consulted by many, so that his private practice is by no means insignificant. If he for any reason loses his position, he starts out with the prestige of his office and the clientele which he has collected while in office. The State officers in law and medicine may be similarly compared.

Advances in sanitary matters are imperative at this age but money is needed to keep abreast of the times.

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THE advances and simplification of the technique of bacteriology are such that many methods may be carried out *Bacteriology in Private Practice.* Dr. W. K. Jacques of Chicago describes, in the *Chicago Medical Recorder*, his outfit, which is very simple. Besides the microscope, slides, cover glasses and a few stains, he has devised small metal boxes of prepared serum which he carries in his pocket. If a suspicious throat be seen a small swab of cotton is made and some of the mucus is smeared on this

serum and the box is put near the body so as to start the incubation as soon as possible, the cotton is burned and the culture is put in a small incubator on reaching home and in a few hours the specimen may be examined.

He always makes the culture from the throat at the first visit before applications have been used, which retard or hinder the growth of the organism. He is convinced that deaths from diphtheria are due to delayed diagnosis, the non-use or misuse of antitoxine. He finds also that different epidemics of diphtheria vary in their character, some being due to the Klebs-Loeffler bacillus alone, while others are a mixed infection. In cases of mixed infection the antitoxine was not as efficacious as in simple infection.

In the case of gonorrhea, malaria, and other diseases, not to speak of pulmonary tuberculosis, the diagnosis by the bacteriological means is simple and usually satisfactory. Dr. Jacques also found cases of vaginal infection in which he found the Klebs-Loeffler organism.

Of course, such a use of the microscope presupposes a knowledge of microscopical technique and some general ideas on simple bacteria staining. Most physicians in large cities can acquire this training and for the good of their patients they should make themselves acquainted with these newer diagnostic aids.

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THE message of the Mayor of Baltimore shows that he appreciates the importance of matters pertaining to hygiene and sanitary science, and it is a novel pleasure to have this high officer call the attention of the city fathers to the needs of a bacteriological laboratory and a hospital for infectious disease, things for which the Health Commissioner has been working for years, in vain up to the present time. It is a great pity that the Mayor cannot have some word in the free school book bill. Surely some precautions should be introduced to prevent the spread of disease, which must follow from the use of books which have been in the hands of those sick with a contagious disease. School books should either cost so little that infected ones can be destroyed or they should be so well made that they may be disinfected and used again.

**Medical Items.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending February 1, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		41
Phthisis Pulmonalis.....		26
Measles.....	115	2
Whooping Cough.....	7	
Pseudo-membranous Croup and Diphtheria.	12	4
Mumps.....	1	
Scarlet fever.....	18	1
Varioloid.....		
Varicella.....	1	
Typhoid fever.....	4	

Dr. Charles Fauvel, the well known laryngologist of Paris, is dead.

The new St. Luke's Hospital in upper New York was opened recently.

Dr. James E. Reeves of Chattanooga, Tennessee, died on January 4, aged sixty-seven.

The death is announced of Dr. F. C. Zeller, a well known German physician of East Baltimore.

The University Press of Columbia College, New York, will shortly publish an Atlas of Nerve Cells, by Dr. M. Allen Starr.

Sir Henry W. Ackland, in a letter to the *Boston Medical and Surgical Journal*, strongly protests against war with England.

Dr. George Dock of Ann Arbor University has been elected Professor of Pathology and Bacteriology in the Jefferson Medical College.

Dr. H. Ernest Goodman, a prominent physician of Philadelphia, connected with the Medico-Chirurgical College and Hospital, died suddenly last Monday.

Paris has 521 foreign medical men among the total 2,922 in the city. It is supposed that New York has more than 600 native American medical men among its 3,000 practitioners.

A company has been organized with the object of providing London with a supply of sea-water direct from the Channel. It is held that there would be a great economy in

using this instead of fresh water to flush the sewers.

The late Baron Larrey, son of Napoleon's surgeon, has left a bequest to the Academy of Sciences for an annual prize of £1000, (\$5000) for the best treatise by an army doctor on any question of medicine, surgery, or sanitation.

Dr. Thomas Opie finds great comfort in driving about the rough streets of Baltimore in the use of a set of bicycle wheels with pneumatic tires on his carriage. His coachman carries the necessary apparatus for immediate repair.

Dr. J. J. Taylor of the *Medical World* of Philadelphia has withdrawn from that journal to establish a new monthly, to be called the *Medical Council*, devoted especially to obstetrics, diseases of women and children and racial improvement.

The January number of the *Index Medicus*, comprising the literature of December and the beginning of January, will be distributed in a few days. The back number, covering a period from May to December, is in the printer's hands. It has been found necessary to slightly enlarge the list of subscribers.

An International Congress of Railway Surgeons is to be held in Brussels in 1897. A committee appointed at the meeting of railway surgeons, which recently took place in Amsterdam, has been asked to report to the forthcoming Congress on the following question: "Should the medical service be a department of the management, Yes or No?"

The Utah State Medical Society, at its first annual meeting, recently declared it to be the sense of the Society, "that every member of it interest himself personally in securing the election of men for the next legislature who favor the maintenance of a high standard of medical excellence in the State of Utah, and that he continue to use his influence."

Dr. Edward Wigglesworth of Boston died there January 20, 1896. He was born in Boston in 1840, and was graduated from the Harvard Medical School in 1865. He served in the Medical Department of the Army for two years during the Civil War. Dr. Wigglesworth spent five years in Europe studying skin diseases. He founded the Boston Dispensary for Skin Diseases in 1872.

## WASHINGTON NOTES.

According to the Health Officer's Report, the health of the city remains somewhat above the annual average. The number of deaths reported during the past week was 112, with a death rate of 21.1 as against 110 in the previous week, and a death rate of 20.7. Three deaths from grippe were reported and two from typhoid fever. The diseases of the heart, brain and kidneys were about at the average. One-fourth of all the deaths during the week were from affections of the lungs, fourteen being from pneumonia and eleven from consumption. Four deaths were due to diphtheria, three to measles and none to scarlet fever. There were 115 births reported. The Coroner reported nine deaths and the Hospitals nineteen.

The Medical Society held its regular weekly meeting on Wednesday, January 29, the President, Dr. Samuel C. Busey, in the chair.

The report of the Committee on Public Health was continued from the last meeting. After that was concluded Dr. Llewellyn Eliot read a paper on Observations on Smallpox. Dr. T. E. McArdle read a paper on Cod Liver Oil as a Food in Medicine.

The Society then adjourned.

## Book Reviews.

**AN AMERICAN TEXT-BOOK OF SURGERY; for Practitioners and Students.** By Chas. H. Burnett, M. D., Phineas S. Connor, M. D., Frederic S. Dennis, M. D., Wm. W. Keen, M. D., Chas. B. Nancrede, M. D., Roswell Park, M. D., Lewis S. Pilcher, M. D., Nicholas Senn, M. D., Francis J. Shepherd, M. D., Lewis A. Stimson, M. D., Wm. Thomson, M. D., J. Collins Warren, M. D., and J. William White, M. D. Edited by Wm. W. Keen, M. D., LL.D., and J. William White, M. D., Ph. D. Second Edition, Carefully Revised. Philadelphia: W. B. Saunders. 1895. Price, \$7, cloth; \$8, sheep; \$9, half Russia. For sale by subscription only.

Sidney Smith exclaimed, "who reads an American book?" This question can now be answered by saying that American books are read by all the world. Twenty years ago the most favored text-books were the production of foreign authors, now we have an extensive series of American systems, which are not only recognized as authorities on this side of the Atlantic, but in Europe as well. An

American text-book of surgery edited by the above mentioned writers appeared in 1892 and met with immediate and unusual success. The first edition has become exhausted and a new and revised edition has been required. The American text-book of surgery forms a royal octavo volume of over 1200 pages, and is illustrated with many handsome plates and wood cuts. The first edition was a faithful exponent of surgical science and art at the time of its publication, three years ago, but during the past three years many important surgical procedures have been instituted, and others which have been recognized as of value in the past are now consigned to oblivion or at least are not held in as great favor as formerly.

The present volume begins with a brief consideration of surgical bacteriology, illustrated with a number of beautifully colored plates. At the present time it is absolutely essential that the surgeon shall have a good knowledge of the germs which cause surgical diseases and materially influence the results of surgical operations. Inflammation and its consequences are carefully considered, as well as wounds, tumors, tuberculosis and syphilis. The second book is devoted to special surgery, such as the affections of the vascular system and the bones. The third book treats of regional surgery, as that of the head and abdomen, whilst the last section or book four is devoted to operative surgery. Time and space are wanting in which to point out the many excellencies of the present edition of this work. It is well known and appreciated and the revised edition brings it up to date in all particulars. It is difficult to see how a volume on surgery could better fulfil its purpose as a text-book than this one. It is neither so voluminous as to be tiresome, nor so condensed as to be merely an epitome, and the reader will find a sufficient description of surgical principles and practice to guide him safely in the management of his own cases.

**THERAPEUTICS OF INFANCY AND CHILDHOOD.**

By A. Jacobi, M. D., Clinical Professor Diseases of Children, College of Physicians and Surgeons, New York; President Association of American Physicians, etc. Philadelphia: J. B. Lippincott Co. 1896.

A very attractive handy volume of 500 pages in clear, large type, and to be commended to the profession without one word of adverse criticism. It presents in simple

terms the experience in therapeutics of one who is widely known not only as a pioneer in the pediatric department of medicine, but a practitioner of enormous experience in this line of work. It is a book for the student and for the practitioner, for the novice and for the ancient. In reading it one feels that he is sitting at the feet of a master of his profession, whose thoughtful comments on the management of one pediatric ailment after another are worthy to be stored away in the memory or noted down for reference in some future difficult case. Unlike many therapeutists the author takes the trouble to go into details concerning the dosage of his drugs and the best manner of administration. As the book is the outcome of a long series of articles in the *Archives of Pediatrics* an additional chapter is given at the close embodying the advances of the last few months.

**MISKEL;** a novel, by L. M. Phillips, M. D., of Penn Yan, New York. Advance copy of No. 2 of the Doctor's Story Series, to be issued March 1. In paper. Pp. 266. Price 50 cents. Baily & Fairchild Co. New York.

This is rather a fanciful tale in which hypnotism plays a prominent part and in which the characters perform all sorts of wonderful and improbable deeds and in the end all turns out right side up and happy hearts are united. The style is bad and the morals are not very good, a fact which in these days will give it a large audience.

#### REPRINTS, ETC., RECEIVED.

**Craniotomy. An Improved Technique.** By A. H. Meisenbach, M. D. Reprint from the *Journal*.

**A Double Current Rectal Irrigator.** By Robert C. Kemp, M. D. Reprint from the *Medical Record*.

**Thoroughness in Medical Education.** By Hunter Robb, M. D. Reprint from the *Western Reserve Medical Journal*.

**Traumatic Separation (Compound) of the Lower Epiphysis of the Femur.** By A. H. Meisenbach, M. D. Reprint from the *Medical Record*.

**The Early Recognition of Carcinoma of the Cervix.** By Hunter Robb, M. D. Reprint from the *American Gynecological and Obstetrical Journal*.

#### Current Editorial Comment.

##### PROFESSIONAL STANDING.

*Cincinnati Lancet-Clinic.*

THE man who is a physician, and is ambitious to be well thought of in his profession, should be identified with a local medical society, and membership in such society should be an insignia of professional reputation.

##### MEDICAL ANNUALS.

*Medical Record.*

THE time was when semi-annual and annual retrospects and summaries, under various names, of the work of the year had their use and value; but in these days of live medical journals, ably edited, unceasingly scouring the world for items of interest, eager to record everything novel both in theory and practice, with exchange lists exceeding in number and variety anything which might be collected in any other way, it would surely seem the medical profession might safely rely upon them, with their voluminous and complete indices, as the most reliable records of each year's work and progress, and more wisely and profitably invest the money which has heretofore been spent upon abstracts, retrospects, and annuals of all kinds, in one or more first-class weekly and monthly medical journals.

##### PHYSICIANS AS LEGISLATORS.

*The Journal.*

THERE is no class of men better qualified to purify politics than honorable physicians, who preserve the high ethical standards of their profession. To say that they will be injured by the associations or that the profession will be degraded by its members taking interest in public affairs, is to state what is not at all a necessary truth; the fact is that those who can be thus hurt are already past the danger point, and the profession is already sufficiently degraded by those who have aided in making too many of our public charities to a large extent mere political machines. What is needed is the entrance of high grade medical men into our legislatures and Congress, and their aid and advice in the framing of our laws. The public welfare is the aim of all legislation, and among its first essentials, if indeed if it is not the first, is the public health.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### THE COPPER KETTLE.

READ BEFORE THE MEDICAL SOCIETY OF WASHINGTON COUNTY, JANUARY 8, 1896.

By *H. U. Onderdonk, M. D.,*  
St. James College, Maryland.

IT would seem an anachronism, in our days, to sound a warning against the dangers and risks attending the use of unprotected copper or brass vessels in the preparation of food, were it not that from time to time we read accounts of whole families being made ill, or of individuals coming to their death, from eating food cooked in these antiquated utensils. I find among our people generally a wholesome fear of them, and that they are not now much in use for cooking purposes, having been to a great measure displaced by the unexceptionable granite ware. But though the old copper kettle may have been deposed from the kitchen stove, it is too frequently made to serve as a kind of general utility vessel, no especial care being taken to keep it clean—that is, bright. In this stage of its history it may become as dangerous, if not more so, than when it was constantly used as a culinary vessel; the popular impression being that the danger from the use of a copper vessel arises only from cooking food in it.

In its semi-abandoned state it is preparing itself to give trouble by taking on gradually a good layer of oxide of copper, ready to be dissolved by any article of food, of an acid, saline or fatty nature, that may be brought into contact with it.

Most housekeepers know that a tarnished copper vessel is not made clean by the simple washing that other cooking utensils get, but that it is only thoroughly clean when perfectly bright. And even in this state they are aware that copper vessels cannot always be used with impunity in the cooking of certain articles of food. Untarnished copper undergoes little or no change by contact with water unless air be present and, under these conditions, there are formed a carbonate and an oxide of copper.

But should the water contain an acid, such as vinegar or any of the acids, or should it contain common salt, or should there be oily or fatty matter in contact with the vessel, then the copper is more readily oxidized, and the liquor or fat becomes of a green color from the dissolved oxide of copper.

If the vessel is kept perfectly clean and the food prepared in it not suffered to grow cold in contact with the copper, but transferred immediately after cooking to other vessels, there is not much risk. However, under no circumstances should any article of food containing an acid, common salt, oily or fatty matter be cooked in copper.

Furthermore, no such article of food should be allowed to be in contact for

any length of time with a vessel of that metal, more especially if the vessel is tarnished.

We all know that the instances are numerous of poisoning from food cooked in copper vessels; and there are cases on record where the charge of wilful poisoning has been brought against the party who prepared the food.

But it is not so well known as it should be that by mere contact with copper for a sufficient time, cold, fatty food may acquire a poisoning impregnation.

It is to this fact that I desire to call particular attention, and I think I can best do it by reciting a case with which I was recently connected, where a knowledge of this fact would have saved two persons from bodily illness, and another from mental anguish. The case in brief is this: I was a short time ago requested to make an analysis for the State, of some food which was suspected to contain poison.

A young girl had been arrested and was then in jail on the charge of putting poison into the food. Two persons, a man and his wife, had been made violently ill by partaking of this food, which had been sent them by the girl. The symptoms as described to me were those produced by an irritant poison. The food was a hog maw stuffed with sausage meat and potatoes, and it appeared that the maw and the meat were sent separately, and that the maw was stuffed at the house of the parties made ill.

I was given a piece of the maw for examination and its appearance was peculiar. The part given me included a portion of the opening through which the meat had been introduced. The edges of this opening were stained green, the coloring making an irregular border of an average width of about a quarter of an inch, looking very much as if the edges had been dipped in green paint.

Taking into consideration the symptoms that had been related to me, the green color and certain other circumstances, I suspected the presence of Paris Green. If a poison had been given with criminal intent, that is the only green poison that is well known and generally available.

Now Paris Green is a compound of copper and arsenic and its poisonous properties are undoubtedly due to the arsenic it contains. Hence, in making an analysis where Paris Green is suspected, we look for the arsenic. However, the preparation of the material for one of the arsenic tests reveals the presence of copper, should the substance under examination be Paris Green. Working upon the hypothesis that I had that substance in hand, I chose to begin with this double test, simply as a preliminary step.

Should my supposition be correct, I would get indications of both elements in one operation. I found that I had a copper compound, as I expected, but when I tested this compound for arsenic, there was no arsenic reaction. I repeated the process with the same result. I was then satisfied that there was no arsenic present and therefore no Paris Green.

As a simple laboratory experiment the test was sufficient, but as the law is not so easily satisfied as to chemical facts as is the chemist, I proceeded to make a thorough and systematic analysis of the green substance, obtaining negative results so far as concerns arsenic, at each step, and demonstrating that no other metal than copper was present.

I was dealing simply with a copper compound. Though perhaps it was not my business to account for the presence of the copper in the food, I was of the opinion that it had gotten there through the cooking of the food in a copper vessel, or that the food had been in contact with one, and I testified to that effect at the hearing before the magistrate.

It was brought out at this hearing that the food had not been cooked in a copper vessel, but that an old copper kettle had been placed, as a measure of precaution, inverted over a heaping crock of sausage meat, and there rested for three days in contact with the meat.

The sausage meat that had been used for stuffing the maw was taken from the top of the crock. The kettle was produced and handed me for inspection. It was badly tarnished within, with the

exception of a bright, nearly circular, spot about six inches in diameter, in the center of the bottom. It is easy to see what had taken place.

The fat of the sausage meat in contact with the kettle had dissolved and absorbed the oxide of copper, leaving that portion which had been resting upon the meat nearly as bright as if it had been scoured.

The maw was stuffed with this impregnated meat and the opening sewed up. While cooking the fat melted and oozed out through the seam, carrying the dissolved oxide of copper with it, and some of this oxide of copper was

absorbed by the fatty layer between the inner and outer coats of the maw, this layer being exposed at the cut edges, either taking it up from the scum while in the vessel in which it was cooked, or from the greasy liquor which accompanied it when taken out of the vessel. The presence of the copper was explained and the prisoner discharged.

By this case the fact is emphasized that there is danger, trial and tribulation in the use of copper vessels, even when food is allowed merely to remain in contact with them, and that poison lurks in the copper kettle, cold as well as hot.

## GUNSHOT CASES.

REMARKS MADE BEFORE THE CLINICAL SOCIETY OF MARYLAND, DECEMBER 20, 1895.

*By Randolph Winslow, M. D.,*

Professor of Anatomy and Clinical Professor of Surgery, University of Maryland.

I AM on the card to open this discussion and will simply report the cases I have seen in the University of Maryland since 1888. During the last three years of my service there we have had four cases of gunshot wounds of the abdomen. Three were operated upon by me and one by Dr. Spruill. The first case upon which I operated has been previously reported to this Society, and is as follows :

CASE I. Man, aged 60. On December 21, 1893, about 6.30 P. M., while stealing coal was shot by a watchman and received a number of wounds of the small intestine. He was brought to the hospital about 1.30 A. M. the next day, and I saw him at noon. There was no evidence of shock and his condition was pretty good. There was a small, blackened area about the external wound, which was situated in the right flank. His temperature was 101°, pulse 104. He was anesthetized, properly prepared for operation and on exploration the wound was found to lead into the peritoneal cavity. The abdomen was opened and flushed out with hot water. Four wounds were found in the bowel and some fecal matter in the peritoneum.

The intestines were washed, sewed up and put back and the abdominal wound packed with gauze, because owing to the free oozing it was thought best not to close it. The bullet could be felt under the skin, near the crest of the ilium, having passed entirely through the bone. The patient was somewhat shocked, but rallied promptly and eventually recovered.

CASE II. This case occurred last year, while I was in Cumberland, attending the meeting of the State Faculty. The man, who had been shot about 24 hours previously, was in a septic condition and had general peritonitis when brought into the hospital. Dr. Spruill promptly opened the abdomen and sewed up the wounds, which were nine in number, but the patient did not rally, and soon died.

CASE III. White man, aged 58. On July 4, while crossing a vacant lot, some boys fired a cannon, filled with big shot, and the man was hit, though at the time he did not feel it. The shot struck him in the left side below the apex of the heart. He walked home and to the hospital. Dr. Spruill examined him, and on introducing a probe

found that the bullet had entered the peritoneal cavity. He had vomited some blood clots. An incision was made in the left hypogastric region, and the stomach exposed. The bullet was found to have passed through the wall of the stomach and the wound was closed by a plug of mucous membrane. No extravasation had occurred. The hole was closed by interrupted sutures. After the operation he vomited blood clots several times. His temperature was  $101\frac{1}{2}^{\circ}$ , pulse 88. He developed bronchitis on the fourth day. The external wound suppurred, but the peritoneum was not invaded, and the patient got well.

CASE IV. This case was not so fortunate. On the 7th of September this man was shot, and brought to the hospital within an hour. The bullet had entered the abdominal cavity, and besides five wounds of the small intestine, there was a number of the mesentery. Laparotomy was performed, the bleeding vessels ligated, perforations closed, the cavity flushed with sterilized water, and the incision closed. The operation was performed at midnight; the patient was collapsed and in such a condition that it was feared he would die on the table, consequently as careful a search as was desired could not be made. The wounds that were found were supposed to be all that were present, but that proved to be a mistake. On September 8 the patient was doing well. September 9, some pain in the lower abdomen. September 10, vomited frequently. Gave enema to cause free movement of the bowels and administered strychnia hypodermically. September 11, five movements, upper abdomen distended, and vomited frequently. September 12, seemed better. Had not vomited for twelve hours. Taking milk and lime water, and calomel every two hours. Died that night. Autopsy showed a hole in the cecum. The wounds that were sutured had held firmly. Unfortunately one hole had been overlooked.

CASE V. My attention was first called practically to penetrating wounds of the abdomen in July, 1881. On the 4th of

July of that year a colored man was admitted to the University Hospital, with a pistol wound, the ball entering the left side of the abdomen at a point  $1\frac{1}{2}$  inches from the linea alba and 3 inches from the umbilicus, making a circular hole, with clean-cut edges, about the size of the end of the little finger, through which about an inch of omentum protruded. There was no hemorrhage, and but little pain, the temperature was normal, and the pulse 80, and full and strong. As I could not replace the omentum it was ligatured and the redundant portion cut off. The wound was slightly enlarged and a drainage tube introduced. Two ice bladders were applied to the abdomen, and a grain of opium administered every three hours. On the third day his temperature rose from  $99^{\circ}$  in the morning to  $101\frac{3}{5}^{\circ}$  in the evening; the pulse from 80 to 126; and the respiration to 32; his abdomen became tympanitic, but there was very little tenderness on pressure. The onset of peritonitis was feared, but the next morning the temperature dropped to  $99\frac{4}{5}^{\circ}$ , and the pulse to 104, and subsequently no alarming symptoms occurred, and the man was discharged from the hospital in 30 days entirely well. This case came under my care just previous to the publication of Dr. J. Marion Sims' famous article advocating laparotomy in this class of injuries, and the favorable result is to be attributed to good fortune, rather than to good treatment. It is evident that the ball spent itself in penetrating the abdominal wall and did not wound the intestines.

CASE VI. Pistol wound of the epigastrium. June 3, 1894. S. P., negress, was shot with a large revolver, the bullet entering the epigastrium one and a half inches from the linea alba, and three inches below the ensiform cartilage. From the situation of the wound it was thought that the stomach, or large intestine, was injured, but there was no vomiting of blood, nor bloody stools. There was some pain, but no elevation of the temperature and she was let alone. She lived five days and two hours, and died with symptoms suggestive of peritonitis. At the autopsy no peritonitis was found,

nor any wound of the abdominal viscera. Some fluid was found in the peritoneal cavity, and the peritoneum detached, with an enormous blood clot under it. A long slit was found in the aorta below the celiac axis, and a counter opening opposite the third lumbar vertebra. There were thus two large openings in the aorta, and yet she lived five days and two hours.

CASE VII. Pistol wounds of the small intestine. Twenty-seven holes in intestines and bladder; death in eighteen hours. C. W., admitted on same day as above. Was shot in the hypogastric region, over the pubes, with a large pistol. One wound was in the hypogastrium and a bullet was cut out from the integument, one inch distant. Another wound was found upon the buttock, near the anus, and a bullet was removed from the skin, three inches distant. Was admitted to the hospital during the night. Pulse good and shock not marked. Urine bloody. When seen by me the next day was in collapse, pulseless, vomiting, and in great pain. Autopsy: The bullets were found to have pursued nearly parallel courses, one entering in front and lodging under the skin of the buttock; the other entering behind and lodging beneath the skin of the abdomen. The peritoneal cavity was filled with blood, feces, pepper pods and cherry stones; the lower portion of the small intestine, for about six feet, was riddled, there being twenty-five holes in the bowel, one in the mesentery, one in the top of the bladder, and one in the base; altogether, twenty-eight wounds as the result of these two bullets.

Laparotomy should have been performed in both of these cases, though there is scarcely a chance that a favorable result could have been obtained. I only saw the last case when he was in collapse.

CASE VIII. Pistol wound of the liver; death in eighteen or twenty hours. D. G., colored; was shot on the same day as the two preceding cases. The wound was on the right side, in the anterior axillary line, about two inches from the nipple, in the fifth intercostal space, and the ball ranging downwards

fractured the sixth rib and entered the abdomen between the sixth and seventh ribs. Much bleeding and marked shock followed. Local pain and pain in the right shoulder. There was no escape of bile from the wound. The patient vomited the contents of the stomach, but no blood. A wound of the liver was diagnosed. The patient never rallied from the shock and died in the evening of the same day. Autopsy: The bullet was found to have passed through the upper surface of the liver and to be imbedded in the substance of the diaphragm.

CASE IX. Pistol wound of the back, perforation of small intestine, death in twenty-nine hours, from peritonitis. W. G., colored, was shot whilst running away from a policeman, the bullet entering his back one inch to the left of the second lumbar vertebra, and a probe could not be made to follow its track. Seven hours after injury the pulse was 82; respiration 32; temperature 98.8°, and there was no shock. Soon pain about the umbilicus set in, and rigidity of the abdominal muscles, vomiting and a bloody alvine dejection and there was numbness of the parts supplied by the left anterior crural nerve. The temperature began to rise and in twelve hours reached 100.2°; pulse 90; respiration 48 and thoracic in character, the abdominal tenderness remaining. A consultation was held in regard to the propriety of performing laparotomy in this case, but the consultant was opposed to it. The patient died of peritonitis in twenty-nine hours. Autopsy: The ball entered the back opposite the second lumbar vertebra, grazed the third lumbar vertebra, then passed into the peritoneal cavity, pierced the small intestine in two places, and finally dropped into the pelvis. Feces had escaped and an intense general peritonitis was set up. Laparotomy ought to have been performed in this case.

CASE X. Gunshot wound, supposed to have penetrated the abdominal cavity. Operation declined. Recovery. Michael Kane, aged 45, admitted December 2, 1893. He was shot a short time before admission, with a pistol, the bullet en-

tering three inches to the left of the sternum and one inch below, just over the left costal margin. Dr. Spruill examined him under an anesthetic and thought the ball had gone into the peritoneal cavity. After examining the man I recommended an exploratory laparotomy, which he declined. No serious symptoms supervened and he left the hospital on December 20. The highest temperature was 101° and pulse 80.

After a consideration of these cases I agree with Dr. Tiffany that a person who comes into contact with a case of penetrating wound of the abdomen has not done his duty if he fails to give the patient an opportunity for life by performing section. A certain number of cases will recover without operation, but such treatment is simply working in the dark, and in those cases it is probable that the

viscera have not been injured. If they have been injured it is almost inevitable that death will follow. No surgical rule is better established than that such wounds should be treated by an exploring section and, if necessary, by the sewing up of the wounds and ligation of vessels that have been ruptured. There are many points in regard to the technique of such operations, which I will not now take up your time in considering, but I wish again to express my opinion in thorough conformity with what has been said, that a surgeon is not justified in permitting a patient to go without laparotomy who has received a penetrating wound of the abdomen. There is but one thing to do in these cases and that is to perform laparotomy and be further guided by the circumstances of the case.

## SURGICAL "DONT'S."

*By I. S. Stone, M. D.,*

Washington, D. C.

THE following suggestions apply to assistants who are taking their first lessons at the operating table. They are perhaps more pertinent and useful to the assistant in private than in hospital practice.

Don't spare the soap and nail brush, thinking the antiseptic wash sufficient for cleansing the hands.

Don't fail to wash the hands after the final cleansing of the abdomen, before taking up the sponge and instruments.

Don't forget to use sponge pressure to check slight bleeding, and do not rub or scrub the wound.

Don't keep your head, hands, or sponges in your chief's line of vision. Don't forget that this is one of the unpardonable offenses.

Don't operate for, but assist, the surgeon.

Don't rashly suggest that he has forgotten something until you know that he really forgets.

Don't allow him to leave a sponge within the abdominal cavity.

Don't apply a sponge to the stump of a veriform appendix or pyosalpinx, and then to the wound. The wound will surely be infected if this is done.

Don't leave such a sponge in your hand, or give it to the nurse, or lay it down where you, or the surgeon, can possibly use it again.

Don't clamp a piece of omentum or bowel unless told to do so by the surgeon.

Don't tie sutures or ligatures unless told to do so.

Don't be too previous.

Don't apply a sponge first to the skin and then to the wound, or within the abdominal cavity.

Don't keep your head near the wound.

Don't be near-sighted.

Don't be a wall-flower before the operation, especially at a private house, but see that everything is in readiness. Intelligence here means the high appreciation of the operator, and he will be sure to call you again and again to assist him.

Don't leave the patient's side for an instant, or look away from the wound, while the abdominal cavity is open.

Don't take home with you sponges which have been soaked with pus. Don't even ask if they may be returned.

Don't leave the instruments to be sterilized just before the next operation, but do so at the earliest possible moment after returning to the office. Never put them away soiled.

Don't forget to have the towels and water ready, or see that the nurse does so.

Don't permit the nurse to attempt more house cleaning than she has time for, especially when a patient needs op-

eration quickly, as in some cases of appendicitis.

Don't allow the nurse to carry heavy buckets of water. Nurses often over-work themselves and are nervous and excited because they undertake more than can be accomplished in a given time.

Don't forget that an assistant must seldom direct others, but must himself do anything or everything to help in the preparation for an operation.

Don't expect any surgeon to have perfect results, even with a faultless technique, unless his assistants are likewise careful, intelligent and conscientious.

**HEMIPLEGIA AS A RESULT OF GONORRHEA.**—In a recent number of the *Neurologische Centralblatt* Dr. Ludwig Bruns of Hanover relates a case, quoted in the *Lancet*, of somewhat unusual character. He remarks that gonorrhea has as occasional complications serious affections of the nervous system only recently recognized. Fournier has described gonorrhreal sciatica, Hayem and Parmentier, Chavier and Tevriean, Spillman and Haushalter, and Leyden (and Gowers in this country might have been mentioned) have published cases of myelitis apparently closely connected with gonorrhea. Engel-Reimers has also described cases of gonorrhreal polyneuritis as well as a case of meningitis. Tambourer has described a case of double hemiplegia following phlebitis occurring in the course of gonorrhea, and Pitres mentions two similar cases of hemiplegia also occurring in the course of the same disease. Dr. Bruns' case was that of a young woman aged twenty who immediately after her marriage became infected with gonorrhea, which, in spite of treatment, caused perimetritis and salpingitis. Soon after this, and without any warning, she was suddenly attacked with convulsions in the right side of the face and tongue and in the right upper limb, especially the hand. The leg at this time was apparently not affected. These attacks were repeated, and during the attacks and for a little time after them there was aphasia. There was paresis of the right face and of the right

arm, and the right leg later became similarly affected, so that when she was seen by Dr. Bruns there were right-sided hemiplegia, complete motor aphasia, and slight blunting of sensibility. There was no headache or vomiting, and the ocular fundi were normal. There was no hemianopsia, the heart was sound, and there was no sugar or albumen in the urine. After this there was gradual improvement, especially in regard to speech, but the motor affection of the limbs still remain distinct and considerable. Dr. Bruns concludes that, looking at the history of the sudden onset, accompanied by epileptiform attacks, the condition determining the hemiplegia was an embolic one, and that the embolism had its origin at the focus of gonorrhreal inflammation in the Fallopian tube. But it is difficult to see how this could happen. An embolus breaking off from an inflammatory focus in the region of the Fallopian tubes would naturally have to traverse the pulmonary capillaries before it could reach the brain. This, of course, is impossible, and if such an embolus had traveled to the heart in the large veins there might have been a pulmonary apoplexy. But how such an embolus could get to the brain we fail to see, and it seems more feasible to ascribe the hemiplegia to thrombosis occurring in cortical vessels, the thrombosis being probably determined by the morbid blood state to which the gonorrhreal inflammation had given rise.

## Society Reports.

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### CLINICAL SOCIETY OF MARYLAND.

MEETING HELD DECEMBER 20, 1895.

THE 315th regular meeting of the Clinical Society of Maryland was called to order by the President, Dr. J. M. Hundley.

*Dr. L. McLane Tiffany* read a paper on GUNSHOT WOUNDS OF THE PERITONEAL CAVITY AND CONTAINED VISCERA.

*Dr. Randolph Winslow* reported some GUNSHOT CASES. (See page 309.)

*Dr. J. W. Chambers*: I have been very much interested in the relation of these cases, and think the position taken is the proper one, that every case of penetrating wound of the abdomen demands a laparotomy. One important point in the consideration of these cases is that no one can draw any deduction whatever from the amount of shock present. There is no relation between the shock and the injury. I have seen recently a man with perforating wounds walking into the hospital with but slight assistance. Another strong point in favor of the operation is that you do not know anything about what has been injured until you open the abdomen. While there is a rule ordinarily accepted that a bullet entering this cavity, and traveling from side to side, makes many wounds, while one from before back will make but few, it can not be relied upon at all, as is shown in one of the cases related by Dr. Winslow. Only occasionally does a patient recover without operative interference, and the operation should be done early. It will be a long time before we can draw conclusions from the cases reported, as they vary so in character. Within the last six months I have operated upon three cases, and all recovered; but previously to that I had operated upon four, and all died. All of my last three cases were operated upon after the injury, while the others were not seen early enough.

*Dr. B. B. Browne*: Some of us remember the paper read by Dr. J. Marion Sims. He was the first to advise laparotomy in these cases, and I was espe-

cially impressed by Dr. Tiffany's résumé, which varies but little from the rules laid down by Sims, I think in 1881, some fourteen years ago. This mode of treatment was at first severely criticised; now, however, the best surgeons recognize it as perfectly correct, and it shows one more important truth brought forth by that great man.

*Dr. H. H. Biedler*: I have had some little experience in these cases, and recently have had several unfortunate ones. In one, a colored boy, who had been shot by one of his companions, an extensive laparotomy was performed, the abdomen being opened, and the incision, which commenced at the sternum, ended at the pubes. Only one wound was discovered in the viscera, and that was closed, the bullet not found. The boy died, and at the autopsy the bullet was found beneath the right nipple. The question arises whether laparotomy had not more to do with the termination of that life than had the injury. I have seen a large number of cases where this operation was done and followed by decided benefit. Another case I saw recently was that of a man brought into the Baltimore University Hospital with a gunshot injury, which I took to be a penetrating wound of the abdominal cavity. He presented evidences of shock, and, by the way, I am not inclined to agree with what has been said to the effect that shock does not play any part in the estimation of what shall be done with the case, but, on the other hand, am inclined to think that if the viscera are injured the patient will have a decided amount of shock. This patient died within a very short time, and at the autopsy he was found to have a penetrating ulcer of the stomach, and a general peritonitis. I think, as all have said, it is wise to make an exploratory incision wherever you have such injuries to deal with; that has been the tenor of the best surgeons for many years. As to the results, and whether it is best to do it in a given number of cases, no one can tell.

*Dr. J. M. T. Finney*: I am sorry I was too late to hear Dr. Tiffany's paper, but his opinions, as I get them from the

discussion, are in accord with the best surgeons of the day. Since the day when Dr. Coley's paper appeared in 1887, in which he reviewed the literature of the subject, there has been very little diversity of opinion as to the advisability of this method of treatment. I subscribe to it most heartily.

*Dr. J. G. Jay:* I agree with the practice generally pursued, as stated by those who have spoken before me, and consider it right to follow this line of treatment.

*Dr. L. McLane Tiffany:* The only point I would speak of now is the question of shock. In my paper I quoted Miles in reference to that shock which occurs with the injury. If the shock is progressive it means internal hemorrhage. When the patient is first seen he may be profoundly shocked and not be much disturbed, but if he continues to become more shocked it means hemorrhage, and is all the more demand for operation. Shock at the time of injury does not mean hemorrhage, but later on it does.

*Dr. Randolph Winslow* reported a case of RUPTURE OF THE LIVER. Laparotomy. Death.

H. E., white, aged 25, admitted to the Maryland University Hospital on September 30, 1895. Whilst riding on the shaft of a loaded cart, about 8.30 A. M., he attempted to get off and his foot becoming entangled in the reins he fell and the wheel passed over his abdomen obliquely, from the right hypochondrium, to the left iliac crest. He was brought into the hospital at once, greatly shocked, with pain in the abdomen, quick and weak pulse, and temperature  $95^{\circ}$ . I saw him at 11 A. M. Face blanched, temperature  $96^{\circ}$ , pulse fairly good, some pain in the abdomen, some bruises over the right side, but none on the abdomen. There was marked percussion dullness over the lower portion of the belly. A rupture of some of the abdominal viscera, probably the liver, with hemorrhage, was diagnosed and laparotomy advised. The operation was performed at 1 P. M. An incision was made in the linea alba, from the ensiform cartilage to the pubes, and

even before the peritoneum was opened the dark color of the tissues indicated the presence of blood in the peritoneal cavity, which gushed out to the amount of a quart or more, when the peritoneum was incised. The intestines were examined and found to be uninjured, but the liver was extensively lacerated on its posterior and inferior aspect in two places. The belly was thoroughly washed out and the lacerations of the liver packed with gauze. The patient stood the operation well and seemed to rally somewhat afterwards, but died the same night, about twelve hours after the operation. At the autopsy the peritoneal cavity was found to be filled with blood, showing that the packing had not prevented hemorrhage. I consider laparotomy to be urgently demanded in this class of cases, though the outlook for a successful result is very poor.

*Dr. J. W. Chambers:* I would report a case of this character which occurred to me some six months ago. A young man racing across the street with a friend, fell, and it was supposed struck his right side on the curb. His friend thought that he was not seriously injured and did not call for medical assistance. He was carried into a store and was kept all night. He rallied toward morning and was then carried home. When I saw him his abdomen was distended, but no dullness could be made out. An operation was suggested to the family, but refused and he died twenty-one hours after the fall. At the autopsy it was shown that the liver was practically torn to pieces. It was crushed, and one part was hanging way down, but not absolutely separated. The gall bladder was not ruptured. There was an immense amount of blood in the cavity.

In another similar case a gentleman was crossing the street ahead of a cab and, it is supposed, was struck by the pole, though those who saw the accident were not sure that he was struck. I was at the hospital when he came in. He was dead when he arrived. At the autopsy most of the liver was found in the pelvis. Scarcely half an ounce of fluid in the cavity. His heart was prob-

ably stopped when he was struck, and he died at once. There was no appearance of injury on the surface, and no hemorrhage.

*Dr. S. K. Merrick* exhibited a POLY-AURAL STETHOSCOPE of his own invention and explained its use. It is designed for use in teaching and will accommodate five students at a time.

H. O. REIK, M. D.,  
Secretary.

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MEDICAL SOCIETY  
OF WASHINGTON COUNTY,  
MARYLAND.

MEETING HELD JANUARY 13, 1896.

THE Medical Society of Washington County met in Hagerstown, Wednesday, January 8, in regular session, with Dr. J. W. Humrichouse, the President, in the chair, and Dr. C. D. Baker, Secretary, at which time the following papers were read:

*Dr. H. O. Onderdonk* of St. James College, Md., read a paper entitled THE COPPER KETTLE. (See page 307).

*Dr. R. L. Edwards* of Hagerstown read a paper entitled THE MICROSCOPE AS A MEANS OF DIAGNOSIS.

Each subject was discussed by a number of members.

The subject for general discussion was THE TREATMENT OF EMPYEMA.

C. D. BAKER, M. D.,  
Corresponding Secretary,  
Rohrersville, Md.

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Medical Progress.

THE PASSING OF THE GARGLE.—The gargle has been often criticised as ineffective and inefficient, says the *Medical Record*, and, theoretically, has been long excluded from rational pharyngeal therapeutics. The *Medical Press*, however, calls attention to the fact that, despite the criticisms upon it, the gargle is still frequently employed, not only in domestic practice, but on the prescription of physicians. The gargle is one of those things which it has been very hard to do away with, because it appeals to the patient, and particularly

to the anxious friends and parents, as being something tangible—something that the patient can do. The ability to gargle, also, has been considered one of the milestones in the intellectual and physiological development of childhood, and has, in the parental mind, often been classed with the achievement of walking or the appearance of non-deciduous teeth. There are about the gargle a great many tender reminiscences of juvenile days and tonsillar swelling, and it is somewhat sad to think that all the earnestness and conscientiousness which the rising and risen generations have thrown into the gentle art have been entirely wasted. The musical gurgle of the astringent solutions bubbling in the throat are no longer to be heard, if the general practitioner rises to the high plane to which modern science calls him. The gentle splash of the medicated fluid, after it has performed its supposed healing function, into the cuspidor or basin, will no longer be heard in the land. *Gargarisma fuit.* All this is because physiologists show that the gargle never really goes beyond the posterior pillars, and is, in fact, only a very nasty mouth-wash, which disorders the taste, discolors the teeth, injures the healthy tissue, and nauseates the palate without ameliorating the pharynx. Mr. Lennox Browne, who writes an epitaph upon the "gargle" as it used to be given, tries to take the pathos from its mortality by saying that there is a form of gargle which may be substituted with some beneficial results. But this particular method, which is that described by Von Troeltsch, is too complicated for any but the trained understanding of the mature and most intelligent classes. It consists in taking a tablespoonful of the medicated solution in the mouth, holding it in the back of the throat, with the head thrown back, closing the nose with the thumb and finger, and making movements of swallowing without letting the liquid go down the throat. Those who have tried this interesting experiment will agree that it is a good deal harder than learning to ride a bicycle, and associated not less often with the disaster that

goes with untrained muscles. We do not believe that the Von Troeltsch method will ever be popular. It might as well, therefore, be admitted that the gargle must go, and should, in fact, be already long gone.

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TREATMENT OF GONORRHEA.—Ulisie and Salvatore (*British Medical Journal*) have tried, with good results, the treatment of gonorrhœa by means of permanganate of potassium solutions made by dissolving 5 grammes of the salt in 5 liters of water. Of this solution about one quarter of a liter was allowed to flow into the urethra through a double way catheter, from a vessel held at a height of a meter and a half. If the posterior urethra was affected the solution was made to flow there by closing the exit pipe of the catheter. After a short time the resistance of the sphincter was overcome and about 300 grammes of the liquid allowed to flow into the bladder. As far as the anterior urethral injections were concerned little more than a mere burning sensation was noticed, hardly any pain. In the case of the posterior urethra some pain was caused, but, as a rule, not severe. The treatment is useful in the very first two or three days, and then later, but not during the acute stage.

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MALARIA AND ITS TREATMENT.—Klein, in an article on Malaria, in the *Therapeutic Gazette*, as quoted in the *American Medico-Surgical Bulletin*, believes quinine to be the only means for the specific treatment of malaria. He prefers the hydrochlorate to the sulphate of this alkaloid, owing to the greater solubility of the former, and because of the larger proportion of quinine it contains. The tolerance of quinine by a patient suffering from malaria is much greater than that of a normal individual. The best time to administer the drug is immediately after the termination of the paroxysm, about an hour after sweating has ceased. The author administers 15 to 21 grn. of the drug, preferably in capsules. The dose for an adult should never be less than 15 grn., given once a day. If the chills do not recur for some

time, the author then gives 12 grn. daily for three days, after this 7 grn. for three days, and gradually diminishes the dose; the treatment must not be stopped abruptly else the chill will return.

To ward off further attacks, to increase the resistance of the body, and to reduce the enlarged spleen, Dr. Klein continues the use of quinine in small doses, just sufficient to keep the system under its influence. It may be given in pills, as follows:

Quinine Hydrochlorate . . . . .	30 grn.
Extract Cinchona . . . . .	30 grn.
Make 20 pills.	One pill three times a day.

Or this mixture may be prescribed :

Quinine Hydrochlorate . . . . .	30 grn.
Tincture Quassia . . . . .	1 fl. dr.
Tincture Cinchona . . . . .	1 fl. dr.
Solut. Potassium Arsenite	$\frac{1}{2}$ fl. dr.
Syrup Orange-flowers . . . . .	1 fl. oz.
Water . . . . .	5 fl. oz.
Two tablespoonfuls per day, before dinner.	

If the hypertrophy of the spleen is of long standing, potassium iodide, in doses of 15 grn. daily, is of value. In addition to this internal treatment, local hydrotherapy should be employed. The patient should be upon the back naked, while 5 to 8 quarts of cold water are poured from a height upon the region overlying the spleen, and this should then be vigorously rubbed for five minutes. Sometimes the fever reappears after this treatment; it should be cured, and then the treatment renewed. After the hydrotherapy, the patient should take a walk or ride, for exercise.

The effects of the above treatment of the disease show themselves rapidly, it is stated, by return of appetite and improved condition generally. Sometimes, however, a change of air or even of habitation is required.

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DOES THE PRACTICE OF MEDICINE PAY?—In answer to this question, Dr. W. H. S. Crabb, in the *Louisville Medical Monthly*, says: Yes, if conducted on business principles, it pays. Does the dry goods business pay? or the grocery

business pay? Yes, if conducted on strict business principles. Sell for a good profit, and assume no unnecessary risk. Do not credit. Do not sell on time unless you are made secure.

Physicians can consume all of their time rendering aid to people who never pay their bills. The more he indulges them the more they ask his aid. But when he presents his bill they are astounded. Thought that the doctor was able to wait with them for twenty-five years; but if the doctor will consent to do their practice in the future they will give him their note. It is needless to say that in ninety-nine cases out of one hundred the note is not worth the paper it is written on. Would rather have you anyhow than old Dr. Blank, who resides in the same town. Have tried him and he did not give satisfaction.

It is a very strange thing indeed, that after a man has spent from \$800 to \$2000 to educate, qualify and establish himself as a physician, that consuming the best years of his life in hard study to qualify himself to practice medicine, that he will devote his time, labor and attention to patients without any hope of remuneration. But when a doctor first commences to practice he wants to get acquainted with the people, and wants to establish a reputation as a physician. The people are aware of this, and know how to take every advantage of him.

The community is aware that a physician must have money or must have friends that are able to help him, or he could never obtain his medical education and establish himself in a practice. The laity do not consider that the better a physician is paid the better he can be posted and prepared for practice. If every physician would require pay for his services when rendered, the practice of medicine *would pay*.

We need some wholesome legislation in regard to physicians' fees. A physician may be required to go ten or fifteen miles on a cold winter night to attend a dying man. Arriving at the bedside he renders all the aid in his power. The patient dies despite all efforts of the physician to save his life. The dead man leaves money. Before the doctor

departs for home some member of the family tells him: "Well, doctor, the affairs will go into the hands of an administrator, and he will settle with you inside of *two years*."

If physicians would exact their fees at every visit, patients would not ask for a reduction or a discount.

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**THE TREATMENT OF FURUNCLES OF THE EYELID.**—Lanvole and Gygax, according to the *Therapeutische Wochenschrift*, as quoted in the *New York Medical Journal*, recommends systematic bathing of the lid with one of the following mixtures:

1. Salicylic acid . . . . 5 parts;  
Borax . . . . . 3 "  
Distilled water . . . . 300 "
2. Precipitated sulphur . . . 3 parts;  
Ammonium chloride . . 1 part;  
Rose water . . . . . 50 parts;  
Spirit of camphor . . . 20 "

In obstinate cases they recommend the daily application of the following wash, not only on the lid, but also among the lashes:

- |                      |   |                   |
|----------------------|---|-------------------|
| Spirit of camphor    | } | each 5 parts;     |
| Precipitated sulphur |   |                   |
| Lime water           | } | each . . . . 50 " |
| Rose water           |   |                   |
| Gum arabic           |   | . . . . . 1 part. |

\* \*

**THE DIAGNOSTIC VALUE OF ILLUMINATION OF THE STOMACH.**—Meinert (*British Medical Journal*) criticises the method of Martius and Meltzing, who claim to have shown that the normal empty stomach extends further up into the epigastrium than has hitherto been admitted, and that the normal full stomach always reaches below the umbilicus. The great question suggested by their researches is whether the appearances resulting from the introduction of the electric lamp into the stomach are due to the simple illumination of the organ, or to the diffusion of the rays of light in all directions. Meinert finds that these appearances vary very much with the position of the sound; thus, when this is behind the liver, the stomach region is not illuminated at all, and all that is

seen is a patch of light far to the right of the umbilicus. On the other hand, when the lamp is brought near the greater curvature, the adjoining colon is also illuminated to a greater or less extent. In dilatation of the stomach the method allows of a fairly accurate estimation of the position of the greater, but not of the lesser, curvature. Meintert concludes that electrical illumination may be of great service in the diagnosis of tumors in the splenic region, and or enlargement of the spleen, and also in the topographical confirmation of many palpable tumors of the stomach and its neighborhood; in the estimation of the position, size, and form of the stomach, its indications are extremely fallacious.

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A STUDY OF CHILDHOOD.—Every one, says the *Lancet*, who has read Professor Sully's "Studies of Childhood" must acknowledge the American child to be a subject worthy of study. But the following delicious production which we received from the medical man to whom it was sent shows, we think, that the child mind in this country is equally interesting. The letter is written upon small pink paper, ornamented with a picture of a pony, and we transcribe it *verbatim*, omitting only names and addresses:—

"Dear Dr.\_\_\_\_\_,—I would be very pleased if you would let me have a Baby for one guinea. We want it on the 4th of Febray for Mother's birthday. We would like it fat and Bonny, with blue eyes and fair hair. We Children are going to give it to her ourselfes please answer at once. —Yours sincerely,  
ARCHIE\_\_\_\_\_."

"P. S.—Which would be the cheaper a Boy or a Girl?"

We commend this to the notice of Professor Sully. The P. S. is delightful, and who is there shall answer the momentous question? The age of the writer—the eldest child—we may add, is seven; and the letter, except for certain paternal instructions as to spelling, given without seeing the letter, is the unaided composition of "we children." We are honored with the acquaintance of a young lady, aged five, who one day remarked, "Father, dear, why is our baby such an unpleasant, common little

thing?" but this only shows from what different points of view children may look at the same thing. We fear that these children have not been instructed by "Baby Buds," or they would know that babies are not procurable by the mercenary method suggested by their letter, but it shows that the real child is still with us.

\* \* \*

OVARIOTOMY AND WOUND OF URETER.—Warnek (*British Medical Journal*), in the course of an operation for the removal of a very large cyst of the right ovary, cut away a tubular structure, which was seen to be over three inches of the ureter. The corresponding kidney was therefore sought for, but could not be found. The upper end of the ureter was fixed in the wound. The patient left the hospital, cured, thirty-eight days after the operation. As no urine escaped from the cut ureter, Warnek thinks it reasonable to believe that the right kidney had undergone atrophy from pressure on its efferent canal.

\* \* \*

TWO PRIMARY CARCINOMATA IN THE SAME INDIVIDUAL.—At a recent meeting of the Berlin Medical Society, Israel (*Medical News*) reported the case of a woman fifty years old, who came under observation on account of gallstones, for relief of which the gall-bladder was incised and its walls attached to the abdominal wall and fifteen concretions evacuated. Death took place suddenly several days after the operation as a result of heart failure, which upon post-mortem examination was found to be due to mitral stenosis. In the wall of the gall-bladder was found a large area of ulceration surrounded by thickening of the adjacent tissue. Microscopical examination disclosed the histological structure of a cylinder-cell carcinoma in places scirrhous. The cystic duct contained a polyhedric stone of cholesterine. The head of the pancreas was further found to contain a chancroid tumor as large as a hen's egg. The retroperitoneal glands presented secondary involvement of cylinder-cell character.

MARYLAND  
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BALTIMORE, FEBRUARY 15, 1896.

THE recent address of Dr. James R. Chadwick on the occasion of the opening of the new hall and library of *The Medical Library*. The Faculty gave an impetus to the progress of this institution, and this was materially assisted by the generous donations of about four thousand dollars made on that night and as a result of that able address.

Added to this, some very earnest and zealous members of the Faculty conceived the idea of forming the Book and Journal Club of the Faculty, the idea being to obtain annual subscriptions of five dollars each, and this club to supplement the work of the library board and contribute this money for the purchase of books and journals. The hope was that forty members might be induced to subscribe a total of two hundred dollars. In an incredibly short time sixty members had been enrolled, with a subscription of three hundred dollars, and the limits will probably

be touched at a hundred members with five hundred dollars.

Not content with this work, one of the profession in conversation with one of the Frick family of Baltimore, asked why no fitting memorial had ever been erected to the late Dr. Charles Frick, who was cut off in his 37th year, full of promise, and already with a national reputation from his contributions on disease of the blood, renal troubles and the continued fevers. The present condition of the library was explained with the results that the surviving brothers of the late Dr. Charles Frick, Professor in the University of Maryland, who died in the year 1860 from diphtheria contracted from a patient, offered to present a thousand dollars to found the Charles Frick Library, the money being used to purchase books which the library does not already possess and which shall bear more especially on the specialty of Dr. Frick. This money is to be expended in full as rapidly as suitable books can be selected and the additional sum of one hundred dollars is to be contributed annually to perpetuate this memorial.

The prosperous condition of the library can at once be seen. In addition to the regular appropriation given to the library board from the general fund, there will be from three to five hundred dollars expended by the Book and Journal Club, and one hundred from the Frick Memorial fund. Of course the journal and magazine list will at once be increased and it will be a matter of a very few years when the shelf-room will be very crowded.

There is certainly a moral in these generous contributions. It is better to work than to complain, and if any interest in the medical profession shows signs of weakening or flags for want of interest and money, instead of complaining, better results are obtained by arousing general interest and devising a means for improvement. All members of the Faculty are invited to join the Book and Journal Club.

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THE discovery that certain fatal gastro-intestinal catarrhs prevalent among infants were due to the presence *Infant Feeding* and activities of micro-organisms, which produced *to Date.* poisons in milk, but could not affect other food stuffs, marked an era in the treatment of the digestive diseases of chil-

dren. It is a question, however, whether the profession at large has fully grasped the meaning of this discovery. The practitioner has gone off on the trail of milk disinfection, and overlooked the more important indications, which demand that milk shall be wholly discarded in certain cases of indigestion and its place filled by meat and grain products and by egg-albumen.

The physician of the future, if he be wise, will more and more promptly, in cases of severe gastro-intestinal catarrh of infants, drop milk and take to these substitutes. He may try one or other of special infant foods at first, but unless quick relief follows he will betake himself to feeding with other than milk. What may be done by intestinal disinfection during continuation of the milk diet is not yet determined. It is a large undertaking to disinfect a bowel full of milk clots and fermentation products by means of poisonous chemicals, especially the coal-tar drugs, which may vary in their composition and strength.

One becomes very sceptical of therapeutists who make reports on such intestinal antiseptics, fearing lest the observer has secured no effect at all from his drug, or lest a repetition of the dosing in later cases may poison the little patient, perhaps fatally. Is it not wiser to discontinue the fermentable substance (milk) and sweep its half decomposed residues gradually out of the canal by the aid of aperients, until by degrees the stomach and bowels shall have gained sufficient health to be able again to digest milk and to prevent by wholesome digestive secretions its harmful decomposition.

The fact is that very little apparent progress has been made in recent months in infant-feeding, and no wonder! The bacteriologist is unraveling, but slowly, the very intricate processes of bowel-sepsis, and has as yet but little of general interest to tell. The boom-doctor has betaken himself to the elaboration of complicated methods of sterilization, with the production of most impressive and expensive apparatuses; or has flitted to other fields where temporary distinction is easily won. The quiet practitioner of thoughtful ways is working out in his daily rounds the very unpretentious principle of diet-change, and has little worthy of extensive remark to contribute.

The custom started in some cities of order-

ing milk by prescription from public laboratories is rather interesting. The prescription calls for milk containing amounts of casein, fat and sugar, such as the physician deems necessary at the time. Under certain circumstances this might be a great blessing to the community. What it will amount to—whether it will be more than a fad of a few physicians—cannot yet be said. The baby is to be weighed every day to see how he is getting on.

A French observer holds that the dilution of milk with water or barley water for infants is injurious; that the addition of water favors dyspepsia. He gives an amount of undiluted sterilized milk suitable to the age of the child, much smaller in quantity than the diluted feeding ordinarily given to infants. His British translator and admirer weakens, however, when it comes to applying the theory, and suggests that if the baby has derangement of the digestive organs dilution would be desirable.

The experience of some is that if a baby does not get a large enough quantity of liquid at each feeding to comfortably fill his little center of interest he makes the family miserable until additional liquid in the form of barley water or catnip tea is administered. This is very inconvenient to the mother and probably amounts to the same as if the milk were diluted at the first.

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THE new photography is now the subject of discussion in lay and technical journals.

*The New Photography.* The ability to photograph through opaque bodies opens up immense possibilities, and would-be celebrities are now rushing into print with the results of their work in locating bullets, bits of glass and other foreign bodies in the hand, foot and other parts of the body.

The discovery of Professor Roentgen has attracted the whole scientific world, and as soon as the public has ceased to wonder and the discovery has been fairly tested, perhaps some practical results of this apparently wonderful power will be made public through proper channels. The pictures taken so far are indeed a wonder, but it remains to be seen what is in the realm of possibility for this light and its powers of penetration. A cut in another part of this issue gives an idea of what has been done.

## Medical Items.

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We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending February 8, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		34
Phthisis Pulmonalis.....		33
Measles.....	78	2
Whooping Cough.....	8	1
Pseudo-membranous Croup and Diphtheria.	18	6
Mumps.....	1	
Scarlet fever.....	II	
Varioloid.....		
Varicella.....	6	
Typhoid fever.....	7	3

A case of smallpox was reported in Baltimore last week.

The College of Physicians and Surgeons of Columbia College, New York, will have many new buildings completed by the end of the winter.

The Illinois Supreme Court has decided that physicians cannot be compelled to report contagious diseases or render other service to the public without pay.

The demand for hospital accommodation in Paris is greater than the supply and many persons applying to the hospitals in that city have been turned away in the past year.

Dr. John F. Buffington, a prominent physician of New Windsor, Maryland, died at that place last week. He was in his sixty-eighth year and was graduated from Jefferson Medical College, Philadelphia, in 1856.

Dr. Eliza M. Mosher, formerly superintendent of the Massachusetts Reformatory for Women, has been appointed professor of hygiene and instructor in the woman's gymnasium in Ann Arbor University.

Dr. Samuel Beck, aged fifty-six, of Chestertown, Maryland, died last Saturday. Dr. Beck was graduated from the University of Maryland in 1860 and practiced medicine in early life but soon relinquished that for a political career.

The General Assembly of Virginia is considering a bill providing for the appropria-

tion of \$2500 annually for the necessary expenses of the Board of Medical Examiners of that State. Their services were previously entirely voluntary.

Dr. George M. Gould has established in Philadelphia a medical journal exchange in order to allow libraries to complete their files of lacking numbers. He asks all physicians to send him lists of all books and magazines which they are willing to donate to libraries. This is all done without pay.

The Albert Lévy prize, of the value of £2000 sterling (\$10,000), has been awarded by the Paris Academy of Medicine to Drs. Behring of Berlin, and Roux, Sub-Director of the Pasteur Institute in Paris, for their discovery of the means of curing diphtheria.

For some time past the claims of cider as a temperance drink have been loudly proclaimed; yet in the report of Burghill Asylum, of England, the medical superintendent states that more people were in the asylum through cider drinking than through any other cause.

There is a movement on foot to form a "National Confederation of State Examining and Licensing Boards," with the purpose "of reciprocal inter-State action on the part of the State examining boards." Dr. Charles McIntire of Easton, Pa., is chairman of the committee, and invites correspondence.

Everyone who has visited the French capital knows how recklessly the Paris Jehu drives, but most people will probably be startled by a calculation made by the *Progrès Medical*, according to which the number of persons killed or injured by omnibuses and other vehicles in a single year exceeds the number of victims of railway accidents in France in ten years.

Dr. John B. Hamilton, as editor of the *Journal of the American Medical Association*, is assisted by the following staff: Drs. H. M. Bannister, W. D. Bratton, M. H. S., Leartus Connor, T. D. Crothers, A. L. Gihon, U. S. N., John B. Hamilton, F. C. Hotz, Lucien Howe, Ludwig Hektoen, H. N. Moyer, Frank W. Reilly, John Ridlon, Charles Smart, U. S. A., Frank Woodbury, R. M. Wyckoff, W. B. Atkinson, H. L. E. Johnson, S. D. Brooks, L. H. Montgomery, H. E. Tuley, C. G. Chadwick, E. B. Smith, Wm. Whifford, G. I. Cullen, R. A. Hamilton, and J. L. Rosenberger, Esq.

## WASHINGTON NOTES.

According to the Health Officer's report there has been a decline of over 9 per cent. in the total mortality of the District since the last report. The number of deaths was 101 as compared with 112 of the preceding week. There were thirty-nine deaths from lung diseases, twelve being from consumption and sixteen from pneumonia. But one death from typhoid fever and one from scarlet fever were reported. The annual death rate was 19.0 as against 21.1 by the last report and 17.3 for the corresponding week of last year. The hospitals reported nineteen deaths and the Coroner nine.

The Clinico-Pathological Society held its regular meeting on Tuesday, February 4, the President, Dr. H. B. Deale, in the chair. Dr. Sterling Ruffin read an essay entitled General Paresis. Dr. J. T. Kelley opened the discussion, which was joined in by Drs. F. B. Bishop, a visitor, A. A. Snyder, Taliaferro Clark and E. L. Tompkins.

The weekly meeting of the Medical Society of the District of Columbia was held on Wednesday evening, February 4, the President, Dr. Samuel C. Busey, in the chair. Dr. G. N. Acker reported an interesting case of typhoid fever and presented the specimen. Dr. H. L. E. Johnson presented a specimen of tumor, removed by laparotomy. Dr. J. R. Wellington read the paper of the evening on Castration for Hypertrophy of the Prostate. The paper was discussed by Dr. J. Ford Thompson, who reported cases, and Dr. Forwood of the Soldier's Home, who reported cases that were benefited by castration and one whose prostate atrophied in consequence of the operation but yet he was unable to pass his urine. Dr. A. A. Snyder also reported cases and stated that simple atrophy of the testicle produced atrophy of the prostate gland.

The consideration of the report on Publication of the Transactions was postponed until the next meeting.

The Washington Gynecological and Obstetrical Society held its regular meeting on Friday, February 7, the Vice-President, Dr. S. S. Adams, in the chair. Dr. I. S. Stone presented specimens of very large pus tubes and ovaries. Dr. J. W. Bovée showed two specimens of fibroids of the uterus. Dr. Bovée read the paper of the evening, entitled

Anterior Colpotomy. Dr. H. L. E. Johnson presented cases and specimens of myomectomy. Those who discussed the two papers were Drs. W. S. Bowen, I. S. Stone, W. P. Carr, J. Taber Johnson and H. D. Fry.

Dr. E. M. Hasbrouck has been appointed Physician to the Poor in place of Dr. Allen Walker, whose term had expired.

## Book Reviews.

**AN ATLAS OF OPHTHALMOSCOPY.** With an Introduction to the Use of the Ophthalmoscope. By Dr. O. Haab, Professor of Ophthalmology, University of Zurich. Translated and edited by Ernest Clark, M. D., B. S. (Lond.) ; Fellow of the Royal College of Surgeons, etc. Duodecimo, profusely illustrated. New York : William Wood & Company. 1895.

An introduction of 44 pages gives instruction in the principles of ophthalmoscopy and measurement of refraction by the ophthalmoscope. These instructions are clear enough as far as they go, and they go only far enough to start one in work. Scant explanation of oblique illumination is given, though its importance is insisted upon. Only its use in corneal examination is mentioned. The author regards retinoscopy as the best objective method of determining refraction. He does not speak of measuring myopia by finding the "point of reversal," giving only the reversal of image motion by concave lenses of increasing strength.

The main portion of the work consists of 64 excellent plates showing various appearances of the normal functions, congenital malformations, diseases of the optic nerves, retina and choroid. Very rare troubles are omitted and some common diseases illustrated in different stages. Occasionally the plates seem a trifle diagrammatic; but, for all that, are admirably executed, and instructive. Lens troubles are omitted. Full explanations accompany the figures.

**SPECTACLES AND EYEGLASSES.** Their Forms, Mounting and Proper Adjustment. By R. J. Philips, M. D., Adjunct Professor of Diseases of the Eye, Philadelphia Polyclinic, etc. Second edition, revised, with forty-nine illustrations. Price \$1.00. Philadelphia : P. Blakiston, Son & Co. 1895.

This little book has reached its second edition. It is deservedly popular. There is an interesting chapter on the historic devel-

opment of spectacles, something is said about their component parts, and the grinding of lenses, while the bulk of the work is devoted to such practical clinical matters as fitting of frames, proper centering of lenses, etc.

The author does not, apparently, think lightly of eyeglasses for astigmatic patients. A table is given showing the equivalent prism in prism diopters, centrals and refracting angle. The book is of value to anyone engaged in practical ophthalmology.

#### REPRINTS, ETC., RECEIVED.

**Deaf Mutes.** By Louis J. Lautenbach, A. M., M. D., Ph. D.

**Reports on Asthma and on Biliary and Renal Colic and Calculus.**

**Syphilis in Affecting Life Insurance Risks.** Mutual Life Insurance Company of New York.

**Trismus Neonatorum.** By Edwin Rosenthal, M. D. Reprint from the *Codex Medicus Philadelphiae*.

**New Methods Employed for the Relief of Impaired Hearing, etc.** By Louis J. Lautenbach, M. D., Ph. D.

**Petroleum in Pulmonary Affections.** By E. P. Jones, M. D. Reprint from the *New England Medical Monthly*.

**Granular Lids, with Cases in Practice.** By A. Bratton Deynard, M. D., New York. Reprint from the *Medical and Surgical Reporter*.

**Auscultatory Percussion and Allied Methods of Physical Diagnosis.** By A. L. Benedict, A. M., M. D. Reprint from the *Medical and Surgical Reporter*.

**Various Fractures; Simple and Compound. A Clinical Report of Fifteen Cases.** By Thomas H. Manley, M. D. Reprint from the *American Medico-Surgical Bulletin*.

**The Limitation of Surgical Operations as a Means of Relief or Cure in Epilepsy.** By Thomas H. Manley, M. D., New York. Reprint from the *International Journal of Surgery*.

**Deformities Following Fractures of the Shafts of Bones, with Observations on Treatment.** By Thomas H. Manley, M. D. Reprint from the *American Medico-Surgical Bulletin*.

#### Current Editorial Comment.

##### TOO MANY PHYSICIANS.

*Gaillard's Medical Journal.*

WE do not allege that there is no over-crowding of the profession in the United States, but we do believe that the excess of doctors is not as great as a mere statement of relative numbers might lead one to suppose. The intelligence and comparative affluence of the people of this country as compared with the peasant class of Europe are undoubtedly elements in producing such a large proportion of physicians.

##### THE PHOTOGRAPHIC DISCOVERY.

*Lancet.*

THE newly discovered radiations which proceed from the vacuum tube under the influence of the electric discharge are rapidly opening up, as we suggested two or three weeks ago, an entirely new resource in surgery. It is reported from Vienna, for example, that Professor Neusser has obtained photographs showing gall-stones *in situ* and a calculus in the bladder, taken by means of what Professor Roentgen has called the "x" rays.

##### CANDOR IN CONSUMPTION.

*Northwestern Lancet.*

IN consumption the physician must bring to bear his best judgment, which will sometimes urge him to state the case at its worst, plainly and even bluntly, while again it will show that a somewhat equivocal statement is the best. Only let the medical man look to it that he is guided by the right motive; that he refrain from telling the patient his true condition because that is the best thing for the patient and not because it is less disagreeable for the doctor.

##### THE BLOOD IN MALARIA.

*Medical Record.*

THERE is still scepticism among some competent authorities as to its significance. Recently an East Indian surgeon, Lieutenant-Colonel E. Lawrie, M. B., has written a monograph in which he asserts, as the result of his studies, that this micro-organism is not present regularly in patients suffering from the malarial fevers of India. Naturally, the only argument here is to say that Dr. Lawrie is prejudiced, ignorant, and incompetent; and such answer has been made.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### PNEUMONIA.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
DECEMBER 17, 1895.

By William Mercer Sprigg, M. D.,  
Washington, D. C.

In presenting the subject of pneumonia for your consideration, I do so recognizing that I have nothing new to offer, but to call your attention to an affection in which the mortality is great, and which is most prevalent in this climate, between the months of November and April, and with the hope that by its free discussion at this time we may acquire a more thorough knowledge of its etiology, morbid anatomy, symptoms, diagnosis, prognosis and treatment.

Under the term pneumonia is included lobar, croupous or fibrinous pneumonia, lung fever or pneumonitis, which are infectious diseases caused by a known recognized organism, the diplococcus pneumoniae of Fränkel, and is invariably found in the diseased lung.

*Etiology.*—It is one of the most widespread of all the acute infectious diseases, sparing neither the aged nor young children. It prevails in all classes and at all ages. Males are more susceptible than females, probably due to more frequent exposure. Habits and occupation are predisposing causes. Crowding together in large cities, exposure to sudden changes in temperature, over-exertion, moist atmosphere attended with

prolonged east winds and alcoholism all help to cause it.

One attack of pneumonia predisposes to recurrence. It is very liable to occur in those persons who are constitutionally feeble, or who are suffering with some chronic or wasting disease; as chronic diabetes, Bright's disease, etc., or during the course of protracted fever. Of the exciting causes, exposure to cold is considered the most important, followed by one or more decided chills. Frequently, however, a decided chill is not present. Direct irritation will frequently cause pneumonia by the inhalation of irritating gases, or very hot or cold air, or foreign bodies, such as food. Injury to the chest wall by fracture of a rib or contusion may cause it.

Pneumonia is frequently secondary to various acute debilitating diseases, as measles, typhoid, typhus and especially in pyemia. Pneumonia is now almost universally recognized as a specific infectious disease, depending upon the micro-organism of Fränkel. This view seems well founded because of its frequent occurrence in epidemic form; and that the diplococcus pneumoniae is constantly found and is present in the secondary processes of this disease as

pleurisy, endo- and peri-carditis, meningo-  
itis, etc. Pasteur and Sternberg have  
found the same micrococcus in the saliva  
of persons and this produced septicemia  
in rabbits.

In Netter's observation the diplococcus pneumoniae is present in the buccal secretion of 20 per cent. of healthy persons. It is possible that the various predisposing causes so change the character of the tissue soil that the organism can grow and produce its specific effect. This view seems all the more probable after a study of the experiments of the Klemperer brothers, in producing immunity in animals, by subcutaneous or intravenous injections of a sufficient quantity of filtered bouillon cultures or by injecting the glycerine extract. The immunity, though rarely lasting more than six months, was transmitted to the offspring born within that period.

They found also that the serum of an animal which had been rendered immune had the property of not only producing immunity when introduced into the circulation of another susceptible animal, but actually curing the disease after infection had been in progress for some time. In infected animals with a bodily temperature of 40° to 41° C. (104° to 106° F.) the temperature fell to normal in 24 hours after the injection of serum of another animal which possessed immunity.

They believe that the pneumococcus produces a poisonous albumen (pneumotoxine) which when introduced into the circulation of an animal causes elevation of temperature and the subsequent production in the body of a substance (antipneumotoxine) which possesses the power of neutralizing the poisonous albumen which is found by the diplococcus pneumoniae.

In man they hold that during the pneumonia process there is a constant absorption into the circulation of this poisonous albumen produced by the pneumococcus in the lungs. This continued until the same antidotal substance is produced in the circulation. It is then that the crisis occurs. The pneumococcus is not destroyed nor is its power to produce its poisonous toxine

lessened, but the antitoxine albumen now exists in the blood and neutralizes the toxic substance as it is produced. They demonstrated that the serum of the blood of patients after the crisis contained the antitoxine substance and was capable, in a number of cases, of causing the disease when injected into the circulation of infected animals.

This has been demonstrated upon patients. "In six pneumonia patients the result was promising. In all there was a decided fall of temperature in from 6 to 12 hours after injection of from 4 to 6 c.c. of serum. In two cases it fell to normal and remained so. The serum has no perceptible effect when injected into healthy individuals."

*Morbid Anatomy.*—Pathologists recognize three stages:

1. Engorgement.
2. Red Hepatization.
3. Gray Hepatization.

I will not take up your time by going into a careful description of these stages of the disease. Gray hepatization, however, is the first step in resolution. The exudate becomes softened and the cell elements are disintegrated and rendered capable of being absorbed. When this absorption does not take place, the tissue goes on to purulent infiltration and formation of abscess. The disease may involve only a very small spot in one lung or several spots in the same lung or a small area of lung structure on each side may be involved, or the greater part of both lungs may be involved.

The normal weight of a healthy lung is about 600 grammes; the inflamed varying in weight from 1500 to 2500 grammes. The morbid changes occurring in other organs are both of interest and important. The heart is usually distended with firm coagula, which extend into the blood vessels. In no other disease do you meet with coagula of such solidity and firmness. This distention of the right side of the heart is especially marked.

The spleen is usually enlarged. The kidneys show parenchymatous swelling, turbidity of the cortex and in about 25 per cent. of cases, chronic interstitial

change. Pericarditis occurs most frequently in pneumonia of the left side and double pneumonia. Endocarditis, which occurs about two or four times more frequently than pericarditis, may be either simple or ulcerative. Meningitis may occur and is most frequently associated with ulcerative endocarditis. The meningeal inflammation is usually cortical. The liver shows parenchymatous changes, and is often engorged.

*Symptoms.*—The onset may be ushered in suddenly by a severe chill, or may be preceded for a day or two by indisposition. The chill is usually pronounced, followed by rapid rise of temperature. Pain in the affected side of greater or less severity. A painful, short, dry cough soon develops, with increase of respiration and pulse. Temperature rising by the second or third day to 104° or 105° F. The ratio between the pulse and respiration is greatly changed, respiration being 1 to 2 or 1 to 50 and the pulse full and bounding and rapid. After the second or third day, patient lies flat in bed or on the affected side; the breathing is humid, the cheeks are flushed, the eyes bright, the alae nasi are dilated with each inspiration, the expression is anxious, and the patient winces and holds his breath with each short, hacking cough.

The breathing in pneumonia is almost distinctive. Inspiration is short and superficial, expiration is often accompanied by a short grunt. The cough is at first dry, harsh and hard, without expectoration. Dyspnea is prominent. Respiration 40 to 60 a minute. The sputum may be mucous at first, but later becomes blood-tinged. The sticky, gummy viscosity, together with the degenerated red blood corpuscles, are pathognomonic and is unknown in any other disease. The sputum, microscopically, contains red blood corpuscles, degenerated alveolar epithelium, diplococci, fibrinous casts of the bronchioles, or the expectoration may be absent as in the case of young children and old persons. The quantity is variable after the crisis.

The crisis may occur any time between the third and fourteenth day, or the disease may end gradually by lysis.

In delayed resolution, the fever may persist for several weeks.

*Physical signs.*—At first, inspection on examination may not show any difference in the two sides; later, when consolidation takes place, especially if extensive, there will be a marked difference in the respiratory movements in the two sides, the affected side scarcely moving. The affected side may be larger by measurement. Intercostal spaces not obliterated. Tactile fremitus increased.

*Percussion.*—In the stage of engorgement the percussion note is higher pitched and may be tympanitic in quality, the so-called Skoda's resonance. In the stage of hepatization the note is dull, quality flat. There is not the wooden flatness of effusion and the sense of resistance is not great. On auscultation the breathing is found to be rather suppressed in the affected side. Early there is heard at the end of respiration the true crepitant rale. Later marked tubular breathing. In very extensive cases the tubular breathing may be absent, due to the larger bronchial tubes being completely filled with exudate. When resolution begins, mucous rales of all sizes may be heard.

The red blood corpuscles are reduced. The white corpuscles increased—6000, the normal number, to 10,000 per c.c. This increase disappears as soon as the crisis occurs. Fibrinogen is increased in the blood from 4, the normal amount, to 10 parts per 1000. Vomiting is not infrequent at the outset. The tongue is white and furred, but may be dry in cases of low type. Constipation is more common than diarrhea.

Herpes is not infrequently associated with it. It may occur on the nose, on the genitals, and is supposed by some to be a favorable symptom.

Headache is a common symptom. Delirium and convulsions are less frequent.

Convulsions are more common in children. In drunkards the symptoms from the beginning may be delirium tremens. In the adult there may be violent maniacal symptoms. In senile and alcoholic pneumonia the temperature may be low,

yet brain symptoms pronounced. Mental disturbance may continue after convalescence and in a few cases insanity has developed.

The complications of pneumonia seem, many of them, to depend directly on the invasion of the body by the diplococci. Pleurisy is an inevitable occurrence when the inflammation reaches the surface of the lung. In such pleuritic effusions are found the diplococci in abundance. Pericarditis is more common in children and especially when the left side is affected. Endocarditis is still more frequent. Osler says that in "no acute febrile disease is endocarditis more frequently associated." It is more common in the left part than the right, and is especially liable to attack persons with old valvular disease. Meningitis is a most important complication. It usually comes on at the height of the fever. It may develop later. As it is so often associated with ulcerative endocarditis, there may be hemiplegia, due to embolism of the cerebral arteries. Relapse is very uncommon. Recurrence is more common in pneumonia than in any other acute disease.

*Prognosis.*—As the mortality in this disease is from 20 to 40 per cent., the prognosis is unusually grave. In children and healthy adults the prognosis is good, but in the debilitated, the drunkards, the aged, the outlook is against recovery. Many circumstances influence the prognosis or extent of the disease, height of fever, presence of other diseases and occurrence of complications.

The termination may be more satisfactory and end in resolution in from 5 to 10 days, or in delayed resolution in 3 to 8 weeks; abscess from purulent infiltration; in gangrene, or in fibroid infiltration, this is probably the rarest of all terminations.

The mortality progressively increases, as the following figures from St. Thomas Hospital reports: From 3.7 per cent., five cases under 20 years, to—

22 per cent.	between 20 and 30 years.
30.8 "	" 30 "
47 "	" 40 "
51 "	" 50 "
65 "	" 60 "
	" 70 "

Taken from 708 cases at St. Thomas' Hospital.

*Diagnosis.*—The disease is readily recognized in the large majority of cases by the external character, the physical signs, the sputa, all of which make a very clear clinical picture. In diabetes, Bright's disease, chronic heart disease, pulmonary phthisis, and cancer, the frequent cause of death is pneumonia, and it may be overlooked. In these cases the temperature is probably the best guide, and careful examination of the chest should follow every rise of temperature.

In children the disease may be entirely masked by cerebral symptoms and mistaken for meningitis or pleurisy, with effusion. It may sometimes be necessary to use the exploratory needle to determine the diagnosis.

*Treatment.*—Pneumonia is now recognized by the majority of writers as a self-limited disease and runs its course uninfluenced by drugs. Even under most unfavorable circumstances it will sometimes terminate suddenly, the temperature falling to normal. There is no specific treatment for pneumonia.

The different methods of treatment are as follows:

The expectant, antiphlogistic, stimulant, and symptomatic, have all been advocated. In the majority of cases the indications are to support the heart and lower the temperature and relieve the pain. Morphia, hypodermically, is indicated in small quantities, or some preparation of opium. In Germany the ice poultice is now being used to some extent in the country and the cold bath in distressing brain symptoms attended with high fever.

I have never resorted to the application of the cold pack, or head poultices, or the cold bath in my practice, but have invariably used the oil silk jacket, which I consider of the greatest benefit. If the disease is extensive, dry or wet cupping over the seat of the disease, cold sponging to reduce the temperature if it remains high continuously for more than twelve hours.

The medicinal antipyretics I do not use. Aconite and veratrum viride as

cardiac sedatives, strychnia, whiskey and ammonia, preferably the aromatic spirits, are cardiac stimulants which I use.

If delirium is present, I put an ice cap to the head. The diet should be simple, nutritious, and easily assimilated, and in liquid form.

## THE ENDEMIC FEVER OF THE EASTERN SHORE.

READ BEFORE THE RICHMOND ACADEMY OF MEDICINE AND SURGERY, JANUARY 15, 1896.

By *George W. LeCato, M. D.,*  
Wachapreague, Accomac Co., Va.

AT the request of the Chair, I have selected as the title of this paper a subject I trust will be none the less interesting because commonplace and familiar—"The Endemic Fever of the Eastern Shore."

Twenty years ago the above title would have suggested the discussion of a disease differing materially in most of its essentials from that to which it now applies; for it is absolutely true, as we all know, that our present endemic of continued fever has not only quite supplanted the old types of our former periodical endemic, but is doubtless increasing in prevalence year by year. This fact naturally attaches a certain practical importance to its study and furnishes my excuse for this subject. What I may have to say, however, will be merely cursory, embracing mainly such views as have been drawn from my personal observation, leaving you to take for granted the doctrines of etiology, pathology and treatment commonly accepted by the profession.

In the first place, I shall state, as my individual conviction, that all the forms of continued fever prevailing on the Eastern Shore are of one origin and due to a uniform specific poison. In other words, I believe that all the forms of our present endemic may be safely summed up under the title of typhoid fever—a specific disease, varying from time to time in many of its salient features, like other morbid entities, mainly as the result of peculiar local environment, systemic condition and methods of treatment. This idea is admittedly true of most diseases. No one would expect, at the present day, that pneumonia

would recover, as a rule, under the profoundly sedative treatment of Kasori, or the sanguinary lancet of the phlebotomists of former days. But statistics prove that the success of our fathers, in the treatment of this disease, was quite equal to that of ours. Pneumonia must have changed type in some particular essential; and yet we have the subcrepitant rale, pulmonic consolidation, the rusty sputum, occasional pulmonary edema and even purulent infiltration—the whole sum of pathological sequence. According to my observation, we have, in the continued fever of today, as a rule, the prodromic malaise; the tendency to epistaxis and other hemorrhages; marked sensitiveness of the bowels in spite of constipation; the diurnal cycle of temperature; even rose-spots in some cases; occasional perforations of the bowel—in fact, the well known evidences of a peculiar specific poison, expending its local force in the right iliac region and in the presence of which our antiperiodic sheet anchor is worse than a delusion. Granted that in private practice we are not often permitted the post-mortem evidences of Peyerian inflammation and ulceration, so complete a picture leaves us little room to doubt that the fever of today is the genuine enteric of Geo. B. Wood, the dothinenteritis of Bretonneau and the typhoid of Louis.

True, in an experience of thirty years, I have recognized the disease under varying manifestations. We find at the present day less coma-vigil and muttering delirium, as a rule; we have less trouble to restrain the bowel; cases do not run so rapidly to what is known

as the typhoid state; in a word, there appear to be more mild attacks now than formerly. How much of this may be due to a recent modification in the intensity of the poison, and how much to the present vogue of withholding active medication, may be an open question; but my observation has never led me to believe the essential nature of the disease has sufficiently changed to entitle it to a new name.

I am sure I have never recognized a typical case of Dr. Woodward's so-called typho-malarial fever. As a matter of fact, I have not observed the two distinct types that enter into this supposed hybrid, manifesting themselves unmistakably in the same individual at the same time. I think I have never seen the one type run into or consecutively follow the other. Finally, I have never known any case of so-called typho-malaria to be cut short, or even modified, by anti-periodic treatment. Rather, on the contrary, I have been led to the suspicion that these two poisons are so specifically distinct as to be in some way mutually antagonistic. Certain it is, however explained, that on the Eastern Shore, as elsewhere, the presence of one type, as the endemic, materially qualifies the prevalence of the other. I can recall a period in my earlier practice when continued fever, in Accomac and Northampton, was a comparatively rare disease. The unfortunate reputation the peninsula had earned at that day as a hot-bed for malarious poisoning has not yet been lost, though, as we all know, no longer deserved. If we accept the so-called typhoid germ as the etiological factor in the production of continued fever, and the micro-organism of Laveran as the essential element in paludal poisoning, it would be interesting and instructive to demonstrate the correctness or absurdity of the convictions I have stated; but, so far as I know, these important demonstrations have not been made.

Of the peculiar character of the typhoid poison, we have, at present, only a broad field of speculation and the wonderful revelations of the microscope. Unfortunately, it may be said of the

fashionable microbial theories, that while they have enlarged our learning, they have not greatly increased our practical wisdom. Does the disease really depend upon a microbe? If so, what are the peculiar conditions of its generation? Where does it mainly inhabit—the food we eat, the water we drink, or the air we breathe? And what peculiar change of local condition will explain how and why the typhoid germ of today should have so completely supplanted the miasmatic germ of thirty years ago? These are all practical questions of the greatest importance to us as practitioners—questions for which we are vainly seeking answers, not only from our own observations, but from the scientific investigations of others; for locked up in these mysteries are hidden the problems of prevention and cure. Medical literature teems with plausible theories; you pay your money and you take your choice. Practically, the solution appears as remote as before. I confess that, individually, I have inclined to many different theories along this line. For instance, I had found typhoid so often among families drinking out of polluted and even filthy wells, I became a confessed convert to the poisoned water theory. Ultimately, I had a patient who was herself a crank on this very subject. For months not a single drop of water had been allowed to pass to her stomach that had not previously been boiled. Strange to say, she was the only member of her large family stricken. I can recall a family in which every member was afflicted seriatim, who got their water from a driven pump thirty feet under ground, the pump itself situated on the highest elevation of the premises.

On the Eastern Shore, at least, the water supply derived from underground springs of higher or lower level evidently has no connection with the prevalence of typhoid, as has appeared in other situations,

Another fact, hard to reconcile with the trend of our accepted theories, is that the poison is not necessarily bred in filth. The lady of the household last referred to was an uncompromising

crank on the extremes of cleanliness. Indeed, on general principles, it may be said that the higher the civilization, the more obnoxious we become to typhoid infection; certainly the poor and squalid appear to have no peculiar claims of class distinction to the disease. And so, unfortunately, some practical negation always appears to shut us off in the line of any theory we attempt to pursue. For the present, to be candid, I confess I am entertaining no very settled notions respecting the etiology of typhoid fever. I am inclined to think we know as little of practical value on this subject as did our fathers. They hinted darkly, in their day, at certain poisonous "humors" manufactured in the great laboratory of nature under laws of chemical affinity beyond their chemistry. In the later wisdom of our day, we call these results ptomaines, without being able to explain the chemical processes involved in their generation. The guess of our fathers was probably a cloak for their ignorance that fitted as becomingly as the newer cut of a later day, and doubtless they wore it as honestly. And I am verily coming to believe, in my own mind, the time is not distant when the ptomaine—the old "humor" of our fathers—will play a stronger rôle in fashionable etiology than the present popular and omnipotent microbe. History repeats itself in many divisions of human research. It may be we are already drifting backwards towards the theory of our fathers, to take new bearings from old landmarks and lay out new lines of research not so much in the domain of bacteriology as in the expanding and limitless field of spontaneous toxicology.

I have never believed for a moment in the contagion of typhoid fever. It may be infectious in certain ways not well understood. Its specific poison is doubtless localized, and those obnoxious to it, exposed to like conditions, experience like results. I think I have never discovered stronger evidences of the contagiousness of this disease than apply with equal force to malarious fevers and even common colds.

I shall not consume a moment with reference to its symptomatology. We all agree that the diagnosis is often difficult and sometimes impossible in the earlier stages; but that the thermometer may be safely trusted to settle the doubt, even short of those characteristic features common to its full development. And, in the matter of prognosis, I shall simply say there is no disease known to us of so grave a character, involving so long a course of continued pyrexia, and subject to so many complications and accidents, that so often ends in complete recovery. Still, the maxim of prognosis laid down by the older writers has probably never been improved upon, namely, that while no attack is so desperate as to encourage despair, there is none so mild as to be without danger.

What I may say of the treatment will be in nowise exhaustive—having reference mainly to my own views and practice—not because I wish to appear egotistic, but because I desire to invite discussion; to draw out a comparison of opinions and experiences for my own instruction as well as yours. I have held for many years that the professional world should long ago have reared a monument to that philosopher, Pittcairn, who, when asked what he thought of a certain treatise on the cure of fever, replied, "I do not like fever curers. You may guide a fever; you cannot cure it. What would you think of a pilot who attempted to quell a storm? Either position is equally absurd. In the storm, you steer the ship as well as you can; in a fever, you can only employ patience and judicious measures to meet the difficulties of the case." Perhaps the application of this doctrine, limited to the management of typhoid fever, has not only gone a long way to make the fever of our day a milder disease than formerly, but has really involved the explanation of our present success. Until we unravel the mysteries before alluded to, typhoid will probably remain in the class of so-called self-limited diseases. However revolting to our sense of professional pride, we may as well admit there is no weapon known to our science that will

strike down the malady at any period in its progress, or materially abridge its duration. Among the painful reminiscences of my earlier professional life, I recall to this day the hesitation with which I accepted this fact. And yet what serious disease is there in which more may be done to relieve suffering, ward off danger, and ultimately lead the exhausted victim to recovery?

I have an abiding faith in the thorough, but careful, cleansing of the intestinal canal as a preliminary early treatment. The bowel is to be the battle-ground, and the ileum to bear the main brunt of the contest. If this is not the avenue through which the poison originally reaches the circulation, it is certainly the outlet of depuration, and consequently a dangerous seat of auto-infection. Here the long series of morbid processes are to be carried on, whether we incline to the modern theories of microbial multiplication or the older notions of chemical putrefaction and fermentation.

But the choice of means to this end is a matter of grave importance. My own experience is that the most unpromising cases falling under our observation are those that have been doctored at home with compound cathartic pills and other irritant purgatives. One of the earliest deaths I have ever seen in the disease followed two or three doses of croton oil, administered with the avowed purpose of "touching" an innocent and falsely accused liver. In spite of some recent journalistic assertions, I should not dare attempt the use of any purgative irritant to either the mucous or muscular coat of the bowel. I usually give one or two small doses of calomel, following with salines and large enemata to flush the bowel. I am still old-fashioned enough to believe that calomel unloads the portal circulation, that it stimulates glandular excretion, and that bile limits intestinal fermentation.

An imperative necessity is the regulation of the diet. The victim has a long and doubtful struggle to encounter; the vital forces must be provided for. And yet states of abnormal temperature impair and even suspend the digestive

powers. Solid food is rarely digested, and if it passes into the bowel it must necessarily become not only an irritant, but, if you please, a culture field for microbes, or a fermenting mass that only adds to the tympany, diarrhea, and consequent pyrexia. Fluids are more easily absorbed and furnish little residual bulk. The practice laid down in some of the English hospitals to give no food during the fever that will not easily pass through the meshes of a fine sieve is at least safe. I encourage the free use of water, plain, medicated and flavored. I believe in its refrigerant and depurative action.

Is there anything to be done to limit the propagation of microbes, or abate the tendency to putrefactive changes in the bowel and blood? This is a very interesting practical question, and medical opinion is in nowise agreed upon the answer. A number of years ago I began to give what we know as carbolized iodine, partly on the theory of its germicidal properties, mainly because of the professional policy that demands in all cases some sort of medication. I shall not tire you with any notes on this subject, but will simply say that without expecting marked results my experience has confirmed my confidence in the remedy. Recent observation has inclined me to the belief that the phenic acid in this combination is the valuable factor, and I usually leave out iodine now because it renders the acid less acceptable to the taste. There are few patients who object to small doses of the acid properly diluted and flavored, and to get its results it must be regularly and steadily continued day by day, from early morning until late bed-time. I never give medicine or food during the night, except to meet the demands of a pressing indication. While this remedy is evidently not a direct antipyretic, experience proves that after its administration for several days the temperature falls, as a rule, the diarrhea moderates, the tympany lessens. Recent studies of the physiological effects of phenol appear to indicate that it is not only an antiseptic, germicide and local anesthetic, but a vaso-

motor excitant; Bert and Jolyet claiming that it acts like strychnia on the excitability of the medulla. If this be true, it stands on physiological grounds as an ideal remedy in this and other low forms of fever due to septic poison. This view accords with my own experience. Dr. Robie Wood of New York has lately claimed that it tends to prevent the falling of the hair.

The treatment of high temperatures has been, for the past several years, one of the most interesting questions connected with the management of fever. In private practice, the Brandt method of cold baths is an awkward and bunglesome recourse, which may be simply eliminated from present consideration. While I might find a case in which I should be tempted to employ it, I have not yet found such a case. I rarely use any internal medicine for the reduction of temperature. I experimented in my own individual case, during an attack of this disease, with some doses of the coal tar derivatives, and I shall never attempt this treatment again. My personal conviction is, that under the readings of the thermometer we are apt, in this day, to grow unnecessarily apprehensive in the matter of temperature, and lose sight of other indications hardly less important. It is undoubtedly true that high temperatures coincide with desperate conditions, but as to which may be the cause and which the effect is always a question of practical interest. For instance, an excessive temperature induced by a mass of fermenting milk-curds in the bowel could not be scientifically and appropriately treated with a cold bath. And it is wise in all cases of hyperpyrexia to investigate for any possible condition that may explain the rise of temperature with the hope of being able to apply treatment to the cause rather than the effect.

In spite of the commonly accepted view of damage to the integrity of animal tissues under high temperatures, I believe our apprehensions are in danger of being over-excited. Experiment has demonstrated, time and again, the remarkable resistance of the human body to extremes of heat, even under long

exposure. It is a question, then, how far we may be justified in our efforts to reduce temperature that involves either prostration or unnecessary perturbation. I can recall several cases of this disease, making good recoveries, in which the average of minimum temperature did not fall below  $105^{\circ}$  for eight days; and experience has certainly taught me to look with more anxiety to the pulse for a warning of peril than to the thermometer. Sponging, either cold, tepid, or warm, over the whole body, and continued more or less persistently during much of the afternoon and evening, when the maximum range is being reached, has rarely failed, in my practice, to moderate the temperature and promote comfort and sleep. The end is thus attained without unnecessary fatigue, dangerous movement, or even mental shock. In addition, I have sometimes given one or two doses, 5 grains each, of antikamnia and quinine, during the afternoon and evening, for the purpose of anticipating and prolonging the remission, softening the skin, and securing quiet sleep.

When the patient begins to show signs of muscular prostration, and the force of the heart's systole is apparently failing, my main reliance for years has been placed on strychnia, given in small doses and often. I feel sure that many a flagging heart may be sustained by this remedy through the trying ordeal of the last weeks of an attack. On the subject of alcohol, I have nothing to add to what you already know, except to say that in late years my doses of whiskey are much smaller than they used to be, and that I expect less from it now than formerly.

Of the manifold incidents and accidents presenting themselves in the course of the disease, I have not the time left to speak. A consideration of these would make up really the most interesting and important part of a paper on this subject. It is exactly here that the best judgment of the physician is most severely taxed and his skill exemplified. It may be said, in a general way, that the doctor who is the most watchful, the quickest to apprehend the peril of complications, and the most re-

sourceful in wisely meeting emergencies, will have the best success. But the field is too broad to be entered. I want to call attention, however, to one, not very frequent, but occasional, distressing symptom in nervous subjects suffering with this disease—more common now than formerly—insomnia. Patients do not always sleep who appear to sleep; are not always properly rested by the apparent sleep they do get, because the sleep is not sufficiently profound. I shall never forget the luxury that a few doses of opium brought to me in the latter stages of this fever. I will add a passing reference to that common and serious event which so often complicates mild as well as severe cases—hemorrhage from the bowel—to say I have found large doses of opium the most useful treatment. The exigency is often urgent and pressing; there is no time to waste on astringents. Peristalsis must be profoundly controlled, and the heart's action also. These threatening cases often do well eventually, but it happens the only case of typhoid fever I have lost during the past four years was a very mild case that died speedily from this complication. I had meant to say something about relapses and recrudescences of fever, so common in typhoid, but this paper has already exceeded its legitimate limits. I can only repeat, it was not designed to be in any way complete or exhaustive; and I submit it merely as a text for this afternoon's discussion, that we may wisely compare views and experiences, and thereby further fit ourselves to measure up to the serious responsibilities of our profession.

### Society Reports.

#### CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.

MEETING HELD DECEMBER 17, 1895.

*Dr. Sprigg* read a paper entitled PNEUMONIA. (See page 325.) In the absence of Dr. Dillenback, Dr. Wellington was requested by the Chair to open the discussion.

*Dr. Wellington* said that the particular kind of pneumonia treated of in the

paper had not been given, whether croupous or catarrhal, and of course the etiology and pathology differed in each. It was a well authenticated fact that the diplococcus pneumoniae that is found in croupous pneumonia is often found in the mouths of healthy subjects and patients afflicted with spinal meningitis.

Most authors agree that morphia is a valuable remedy in the first stage of pneumonia, but contra-indicated in the stage of hepatization. Digitalis is also a very useful remedy in this disease. Expectorants and stimulants are indicated, but antipyretics are not. Sponge baths are good. In children consolidation often begins in the middle of a lobe, and it may be two or three days before physical examination reveals anything.

*Dr. Deale* said that the experiments of the Klemperer brothers, in regard to the pneumotoxine and antipneumotoxine, establish one of the prettiest theories in medicine. Dr. Deale described in detail the theory of the Klemperers, and said that it was not old enough to be very well established, but if it is correct cold baths and cold sponging would be of no avail in pneumonia.

In the treatment of this disease, nitro-glycerine is a most valuable remedy as a heart stimulant and by dilating the capillaries and arterioles. If there is one disease above all others in which nitro-glycerine is valuable, it is pneumonia. Poultices are dangerous and must be carefully used; if they are not, harm is done.

*Dr. Frank Leech* spoke of the pulse in pneumonia and cited the paper of Dr. A. H. Smith on PULSE IN PNEUMONIA as a valuable contribution to the study of this subject. Too much dependence should not be placed in the pulse, but we should also examine the heart. Hyoscine in the delirium of pneumonia is a satisfactory remedy. It should be given in the form of hydrobromate and used hypodermatically in the dose of  $\frac{1}{100}$  grain.

*Dr. Clark* spoke of the experiments of the Klemperers in injecting convalescent serum into patients affected with pneumonia and the effect of high temperature in this disease. There is great

danger unless the profession at large should take these theories *cum grano salis*. Consider the effect of continued high temperature on the body. We must be careful in applying cold to abstract heat, on account of the depression that might follow. Care must also be observed in treating this disease to avoid any exertion of the patient that can possibly be dispensed with.

He remembers a case in hospital practice, of an infant affected with pneumonia; after he had examined and diagnosed the case, the surgeon in charge made an examination of the child to verify the diagnosis; the child expired suddenly about fifteen minutes after the second examination. In his opinion, death was due to the exertion caused by the examination. Sometimes poultices act beneficially, but if the patient is corpulent they are prejudicial. We know that cold causes first contraction of the blood vessels and then a reaction marked by dilatation of the blood vessels. If this reaction does not take place, we should stop cold sponging.

In auscultation of the chest we find that the first sign of engorgement is a tympanitic sound and there may be a compensatory emphysema that may cloud the diagnosis. When convulsions occur they are due to high temperature, and in cases of weak heart, failure of circulation causes delirium. In alcoholic patients, delirium is common and is due to weak heart and waste products in the blood. Hyoscyamine is detrimental in pneumonia, because it causes paralysis of the unstriated muscular fibers and therefore impedes the action of the muscles of respiration.

*Dr. Sprigg*, in closing, said that in answer to Dr. Deale's inquiry as to the amount of pulmonary consolidation in his patient, he would state that the area did not exceed two inches in diameter and did not extend to any other part of the lung. In regard to the examination of the heart and pulse in pneumonia, as suggested by Dr. Frank Leech, he would say that the pulse only indicates the force of the heart and the heart should be examined in order to discover any organic abnormality; the

heart should always be watched regardless of the pulse.

Hyoscine hydrobromate was used by him first in the Garfield Hospital, in a case of double pneumonia complicating typhoid fever; it was given after consultation with the board, and notwithstanding the long illness from which the patient was suffering,  $\frac{1}{100}$  grain was given within two hours. The patient slept for the first time in three days and nights; he slept half an hour. It acted most satisfactorily and the patient recovered. He has also used it in delirium tremens and opium hallucinations in opium habitués, but found that it increased the hallucinations. The explanation of Dr. Clark, defective cerebral circulation as a cause of delirium, was exemplified in the case of his patient who had a weak heart. Strychnia and whiskey were here indicated and used.

#### RICHMOND ACADEMY OF MEDICINE AND SURGERY.

MEETING HELD JANUARY 14, 1896.

THE following officers were installed for the ensuing year: Dr. Landon B. Edwards, President; Dr. Jno. N. Upshur, First Vice-President; Dr. J. P. Massie, Second Vice-President; Dr. J. W. Henson, Third Vice-President; Dr. Mark W. Peyser, Secretary; Dr. Wm. R. Jones, Assistant Secretary; Dr. R. A. Nichols, Librarian. Dr. G. W. Le Cato, an invited guest, read a paper on the CONTINUED FEVERS OF THE EASTERN SHORE OF VIRGINIA. (See page 329.)

*Dr. John B. Upshur* said the paper was characterized by good, hard, common sense, and there was very little with which he could take issue. He is in accord concerning the germ theory, but believes typhoid is contagious as well as infectious, and referred to one case infecting every one who came into contact with her until twenty were affected. He believes he contracted the disease immediately from his mother. Dr. Upshur said he was interested in the statement that bilious fever had been replaced by endemic typhoid on the

Eastern Shore and thinks it due to the removal of forests and consequent free ventilation from salt water; but he does not see why typhoid should exist there, taking into consideration the care taken with farmhouses and surroundings. He is in accord with Dr. Le Cato concerning treatment, especially with regard to strychnine. The Woodbridge treatment, the philosophy of which he said he could not understand, was referred to.

*Dr. J. S. Wellford* said he was satisfied that there was such an entity as typho-malarial fever.

*Dr. Arthur Jordan* stated that in typhoid there were certain indications in the blood in the first week—absence of leucocytosis. In the second week there is a leucocytosis, but it differs from that of other acute inflammations in that it is a lymphocytosis. In malaria there is always the plasmodium. Therefore, it seems that a microscopic examination of the blood will demonstrate whether or not there is typho-malaria.

*Dr. J. P. Massie* inquired if Dr. Jordan meant the disease was a hybrid.

*Dr. Jordan* responded that the disease known as typho-malaria has not brought out any distinct appearance. Investigations have failed to show that the plasmodium and Ebert's germ are present at the same time and exerting at the same time their specific influences.

*Dr. W. S. Gordon* thinks Dr. Le Cato has arrived at the practical point. His studies have shown that where there is a dearth of civilization there is malaria; but as soon as the country becomes settled and drained, typhoid appears. Therefore, we must look to civilization for the cause. It is hard to understand how two specified germs acting at the same time can produce a modified disease. He grants that one can have two specific fevers at the same time; but why do we not have the specific manifestations of typhoid and malaria simultaneously? Chills may be seen in true typhoid. We are bound to the fact that we must establish the main symptoms, e. g., recurring chill of malaria. Osler has established the fact that the so-called typho-malaria is typhoid.

*Dr. Upshur* brought up the question of contagion. If the disease is of germ origin, it must be granted that it can be conveyed by air or water. He is rapidly coming to the belief that it is a water-borne disease and we must look to fluids as the carriers. Dr. Gordon referred to an epidemic occurring twenty-one days after partaking of water from a well he had condemned. Concerning treatment he is of the opinion that, in spite of Pepper's nitrate of silver and others, we have not yet arrived at any specific course.

*Dr. Hugh M. Taylor* stated that he had failed to observe in atypical typhoid fever any manifestation to justify the suspicion that it was in any way related to malaria. Certainly, in his hands, such anti-malarial remedies as quinine not only did no good, but did harm. He thought everything tended to show that the term, typho-malarial fever, is a misnomer. He is wedded to the idea that the poison of typhoid is water- or milk-borne, the exceptions being so few that they are not worth considering. As far as his observations go, there is very little well manifested malaria in Richmond and he does not think he sees one case of chills and fever in a year, but we do have our share of typical, as well as atypical, typhoid.

As to the possible existence of two specific germs existing and operating at the same time in patients, he does not think it impossible. In exceptional instances in typhoid there is developed an osteo-myelitis, limited, as a rule, in extent, with a strong tendency to symmetrical development, and to suppuration. Whence comes this pyogenic micro-organism? Has the typhoid bacillus, under changed environment, acquired pyogenic properties, or has there been created by the systemic depression of typhoid a *locus minoris resistentiae*, and a suitable point for the lodgment and morbid action of pyogenic organisms brought to the point of lessened resistance by the blood? It is known that one can have typhoid and pneumonia; can have the product of the tubercle bacillus infected by pyogenic matter, and both will contain material potent for lo-

cal and systemic injury to the tissues. Infective arthritis exceptionally occurs in connection with typhoid fever, as well as other specific fevers. This inflammation may or may not go on to suppuration. If it does, is the suppuration due to pyogenic properties assumed by the specific germ of the disease, or to pyogenic microbes imported from without and transported to the joint by the blood; or is it a result of the combined action of the two organisms? This is an unsettled problem, but in view of the fact that the typhoid bacillus and the comma bacillus of the colon have so many points in common, he does not see why the typhoid bacillus may not, under changed environment, assume pyogenic properties as well as the bacillus coli communis.

Dr. Jacob Michaux asked, may not the disease be entirely distinct from either typhoid or malaria? He is very much disposed to believe it is a different affection, looking at it from either point of view. In treatment, he thinks water is of great value in depuration; and he is surprised at the injunctions limiting it. It is the medium of exchange in the body, and plays a great part in elimination. Taken internally, or used locally, it acts upon the skin, reducing temperature. Strychnine is a decided advance in treatment.

Dr. Upshur remarked that one may have typhoid in a malarial district, the latter impressing itself upon the case. Post-mortems show how malaria affects the ulcerations of the bowels, the edges having characteristics almost distinctive.

Dr. Le Cato, in concluding, said he was glad his paper had brought out so many points and had directed the discussion into such various channels. He remarked that each case of typhoid does not present all the symptoms, but taking them as a whole, we have a complete picture. Variations or exceptions do not vitiate the rule, and it is unfair to assume that because of a mild attack, the same poison does not lie at the cause. In his country, the prodromata are those of typhoid; slowly increasing temperature, tendency to hemorrhage, tympanites, especially the latter. In these cases we

have an accurate description of typhoid. He has never yet been able to learn that the germs of typhoid and malaria have been demonstrated to exist at the same time. He thought he had satisfied himself, beyond cavil, that typhoid is water-borne, but late observations have shaken his belief. He cited a case in which the patient refused for two months to use unboiled water and had quarantined her residence, and yet she contracted typhoid. Other instances occurred in a house situated at the river's edge on a sloping bank, water being supplied by a driven pump 30 feet deep. Tenement houses were situated lower down. These escaped, while the former was affected.

MARK W. PEYSER, M. D.,  
Secretary and Reporter.

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### Medical Progress.

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EPIDEMIC CEREBRO-SPINAL MENINGITIS.—Jaeger (*British Medical Journal*) considers the etiology of epidemic cerebro-spinal meningitis. In 60 to 70 per cent. of recorded cases in which the point has been investigated, Fraenkel's diplococcus lanceolatus has been found. Jaeger investigated 10 cases, and found that in two in which there was definite pus formation the diplococci were present in enormous numbers; in those in which only fibrinous exudation existed the micro-organisms were scantier. Unlike the gonococcus of Neisser they were found inside the nucleus of the cells. From their difference in pathogenic properties, their long vitality in cultures, and from the fact that they appeared in culture as oval forms, sometimes collected in chains divided in the long axis, he concludes that the micro-organism is not the pneumococcus. He therefore proposes to call it the "diplococcus intracellularis," and regards it as the true cause of epidemic cerebro spinal meningitis, looking upon the presence of the pneumococcus as merely secondary, and as frequently obscuring the presence of the diplococcus intracellularis.

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BALTIMORE, FEBRUARY 22, 1896.

THE introduction of subcutaneous tenotomy by Strohmeyer in the early part of this century marked a n

*Operating in* era in the history of *Long-Standing Club-Foot.* orthopedic surgery.

By this means many deformities which could not be otherwise cured were brought to a successful termination.

But valuable as is this surgical procedure, there are limitations to its usefulness. In the young child the ligaments and tendons are lax and easily stretched and the bones are soft and their articular surfaces yielding, hence an infant may readily be cured of club-foot by manipulation, aided, if need be, by section of certain tendons. But when the child has reached ten to fifteen years of age, the ligamentous structures have become much stronger and the bones and their articular facets have become firmly moulded into abnormal shapes and positions, hence simple division of the tendons is not sufficient to effect a cure. In these cases various more or

less extensive operations have within recent years been instituted.

Dr. A. M. Phelps of New York has introduced a valuable operation for the cure of such cases and in many instances a successful result has been obtained. Phelps divides all the tissues on the inner side of the sole, from the skin to the bones, cutting all obstructing bands, whether integumental, fascial, muscular or ligamentous, and then forcibly stretching the foot into proper position, he allows the gap in the tissues to heal by granulation, putting, as it were, a splice into the foot. Another method is the excision of a wedge-shaped piece of the tarsus, so that the foot can be everted; the base of the wedge being on the outer aspect of the foot. This method is also capable of giving a good result, but at the sacrifice of many of the articulations of the foot, with a corresponding loss of elasticity in gait. More recently it has been the fad to excise the astragalus, and many surgeons are well pleased with the results obtained.

In Baltimore this operation has been practiced largely for a number of years. One can readily appreciate the disadvantages of total ablation of the astragalus. It not only shortens the limb, but it brings the articular surfaces of the tibia and fibula in contact with the os calcis, a bone which differs in configuration from the astragalus, and hence not well adapted for the performance of the functions of the ankle joint. That a good result can be obtained after such a mutilation is an illustration of the wonderful recuperative powers of the animal organism.

Dr. Reginald H. Sayre, in the *American Medico-Surgical Bulletin* of December 15, 1895, presents an interesting discussion of the relative merits of removal of the astragalus and forcible manipulation in the cure of varo-equinus. Dr. Sayre had a very severe case of double varo-equinus on the right foot; he excised the astragalus and was not satisfied with the result gained. He therefore concluded to try forcible reduction on the left foot, and by the use of great force, with division of the tendons and ligaments, he succeeded in overcoming the varus, but could not obtain sufficient flexion at the ankle to obviate the equinus. He therefore removed a wedge from the tibia and fibula above the ankle joint with its base forwards and the foot was easily brought to a right angle with

the leg and promptly healed in that position. He also did the same operation on the right foot and succeeded in improving the position of that foot also, but he was struck with the greater elasticity and ease of gait in the left foot, which had an astragalus, in comparison with the right, from which the astragalus had been removed.

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THE gradual lengthening of the medical course in this country has led a few to ask if the longer term nec-

*Home and Foreign Study.* essarily means an ad- vance in medical education.

A correspondent writing from Berlin to the *Pacific Medical Journal* shows the lack of reciprocity in matters medical between Germany and the United States. He calls attention to the ease with which most foreigners may settle down and practice medicine in this country and what difficulties beset an American physician who would practice in Germany. Then follows a comparison of the courses in this country and abroad and the results of this comparison, as every one knows who has studied in Germany, compels one to ask if a long course necessarily insures the best kind of instruction.

The schools in this country, too, should carefully consider what they will give their students in a course of five years. In Germany, for instance, the great freedom allowed students encourages cutting lectures, and in the time the average American student is really working and absorbing knowledge, his German colleague is spending a part of the day fencing and fighting duels and is using up a great part of the night drinking beer.

Harvard will follow the example set by one school in this country, namely, the Johns Hopkins Medical School, in demanding a Bachelor of Arts degree for admission and the more advanced schools are requiring four and five years for a medical degree.

In the course of a few years these schools which have lengthened their terms will add further facilities and so subdivide instruction as to give more personal attention to each student, which will be a material advance.

Post-graduate study abroad is a luxury which will well repay the outlay, but under-graduate study is best followed in this country where there is a certain amount of compulsion and where real work is done during each term.

THERE has been more or less attention given of late to the spelling in medical journals, and the varieties run all *Medical Spelling.* the way from the conservative orthography of the English journals to the unscientific and bold strokes of some American publications.

The absence of an Academy or an authority which shall fix the proper spelling of a word has made many a would-be reformer set out to recast the English language on his own ideas and force his unphilological compounds down the unwilling throats of his readers. The better class of journals usually take the middle course and use only such changes which time and usage have rendered safe. This varied manner of spelling has made the work of writing particularly burdensome to the naturally poor spellers.

The English journals have been publishing a number of letters from persons tending to show that mistakes in spelling do not necessarily stamp a man as uneducated, as some persons cannot spell under any circumstances and all writers have been known to stop, hesitate and finally refer to the dictionary for authority on the most simple word. Spelling is certainly automatic and he who stops to think when in doubt is lost. Spelling is by unconscious cerebration, just as type setting, piano playing and such work. Some children at school are much better able to spell correctly than others and the poorest speller is looked upon as an unfortunate who will never amount to anything. In too many cases now the poor speller is supposed to be an eccentric genius.

Medical spelling has for its basis a knowledge of Latin and Greek especially and with these as a help the most difficult words may be made out by association with their derivation. It is usually the lazy persons and those not well up in ancient languages who bring forward a form of spelling which has no philological basis. Language is a part of the history of the people who use it and to make changes in cold blood and not sanctioned by custom and long use tends to a philological anarchy which should not be encouraged.

The *Journal of Experimental Medicine*, to be published under the auspices of the Johns Hopkins University, will adhere to the conservative method of spelling to the extremest degree.

**Medical Items.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending February 15, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		40
Phthisis Pulmonalis.....		18
Measles.....	120	3
Whooping Cough.....		2
Pseudo-membranous {		
Croup and Diphtheria. }	6	4
Mumps.....		
Scarlet fever.....	15	1
Varioloid.....		
Varicella.....	2	
Typhoid fever.....	3	3

Diphtheria is unusually prevalent in London.

Dr. Mary Sherwood has been appointed by the Mayor as a trustee of Bay View Hospital.

Dr. J. W. Long of Richmond, Virginia, has removed to his new offices, 200 West Grace Street.

Dr. George Dock, who was recently called to Jefferson Medical College, has refused the call and will stay at Ann Arbor.

Surgeon-General Sternberg is opposing the anti-vivisection bill introduced into Congress by some misinformed enthusiasts.

The new hospital presented to the city of Carlisle by the widow of the late ex-Congressman Lemuel Todd was dedicated last month.

Typhoid fever is unusually prevalent in the State of Connecticut. Out of one hundred and sixty-eight towns in the State, the disease is reported in fifty.

The Golden Jubilee of Dr. G. Lewin, the well known dermatologist, was celebrated in Berlin recently under the auspices of the Dermatological Society.

Twenty thousand insane patients are now under the care of the State, and in city and private institutions in New York State, an increase during the year of 736.

Dr. Alexander E. Edwards of Brownsville, Washington County, Maryland, was accident-

ally killed last week by a railroad train. Dr. Edwards was graduated from the University of Maryland in 1861.

A Kansas doctor not long ago advertised that he would lecture in the town court house on "How to keep well," but he had to postpone the lecture on account of illness.

The San Francisco City Council has prohibited bicyclers from holding on their machines any child under the age of six years. This is the outcome of a recent crusade by the Society for the Prevention of Cruelty to Children. We trust the movement will extend.

The Scientific Education on the Temperance question in public schools is not popular in Brooklyn, the comptroller of that city having refused to supply the twenty thousand dollars for the purchase of books on that subject. The objection is perfectly reasonable, says the *Medical Record*.

The Emperor Francis Joseph has issued a decree which provides that women at the Hungarian universites may now be admitted to the medical and philosophic faculties, and thus enabled to become chemists, doctors and professors. There is, however, a saving clause which renders it necessary that permission be first obtained from the Minister of Justice.

A medical club, limited, has been founded in Liverpool, with a capital of £1000 (\$5000), in £2 (\$10) shares. The objects are to establish and maintain a club for members of the medical profession, in particular those practicing in Liverpool and its vicinity. The directors have been decided upon to the number of fifteen, of whom ten are general practitioners.

The St. Louis Health Department makes free microscopic examinations of sputum for tubercle bacilli. The Health Commissioner asserts that certain doctors send specimens to the Health Department for examination, and then charge their patients \$5 each for this. Such a proceeding does not seem right to the Health Commissioner, and is not in accord with medical or other ethics. When a government, however, undertakes the job of providing free examinations, free medicines, free inspections, free vaccinations, free disinfections, etc., it must expect some friction before the state of perfected paternalism is reached.

## WASHINGTON NOTES.

From the Health Department we get the following report: The deaths reported during the last week numbered 107, six more than occurred during the preceding week. The death rate was therefore 20.2; during the preceding week it was 19.0 and during the corresponding week last year 20.3. Diseases of the lungs constituted the principal cause of death. In 29 instances these were of an acute type, including 21 cases of pneumonia. No new cases of diphtheria have been reported. Of those existing at the date of the preceding report, three died and ten were discharged from quarantine. Scarlet fever is somewhat more prevalent, as indicated by the report of sixteen new cases. During the week, however, two cases have been pronounced cured and not a single death has occurred from the disease. Two fatal cases of typhoid fever were reported. Twenty deaths occurred in the hospitals of the city and six cases required investigation by the coroner.

The regular meeting of the Medical Society of the District of Columbia was held on Wednesday, February 12, the President, Dr. S. C. Busey, in the chair. Dr. S. O. Rickey read a paper entitled "Foods and Fashions in Surgery."

The regular monthly meeting of the Board of Directors of the Central Dispensary and Emergency Hospital was held on Friday, February 14.

## Book Reviews.

**THE FUNCTIONAL EXAMINATION OF THE EYE.** By J. Herbert Claiborne, Jr., M. D., Adjunct Professor of Ophthalmology in the New York Polyclinic; Instructor in Ophthalmology, College of Physicians and Surgeons, New York, etc. 100 Pages with 21 Illustrations. Price \$1.00. The Edwards & Docker Co., 518 and 520 Minor Street, Philadelphia.

Dr. Claiborne puts in the form of lectures, very simply and clearly, the fundamental principles of vision, examination of eye function and action of lenses. There is much to commend in these lectures. There is, however, to our mind, error in part of his

teaching. The effort to simplify has been carried too far, and difficulties passed over which it is the function of the special post-graduate course to explain.

On page 39 we read: "If a person reads  $\frac{20}{20}$  on the card . . . . he must possess emmetropia or hyperopia." The addition of + O. 25 S., with its rejection, is then explained; and on page 40, it is claimed that such a patient "must possess" emmetropia. We venture to say that one holding hard and fast to this doctrine will let many a child go on with headaches and asthenopia, in whom there would have been diagnosed, by a glance at radiating lines, astigmatism of low degree, which, while not interfering with visual acuity, was causing pain.

Again on pages 43 and 44: "The patient reads  $\frac{20}{100}$  in each eye. . . . I place a plus 50 D. in front of his right eye. He says he sees worse. He cannot be hyperopic; he must be either emmetropic with disturbance in the media or fundus, or myopic. I now place a covered glass in front of the same eye and . . . he sees no better. . . . The cause of his poor vision is not near-sight either. He must have some disturbance in his media or fundus, and the great probability is he is emmetropic."

Again, we believe that there are many cases, especially among studious children, whose functional symptoms are precisely the above; yet the ophthalmoscope shows hyperopia, and after mydriasis plus glasses (spectacles or eyeglasses) give normal vision. The author seems to have some misgivings, for he adds (pages 44-45): "There is here such a thing as a spasm of the accommodation. . . . but so far as you are concerned in the functional method, the above conclusion is sound and good." Also on page 42 he speaks of "an obstreperous muscle of accommodation," which "will not relax its tension in hyperopia." The functional symptoms of this he gives in the chapter on mydriatics (page 82), as "alternate or irregular clearness and dimness of letters;" contradictory or uncertain answers, "headache."

According to our experience, the quotation above, from pages 43-44, exposes frequent symptoms of this condition. The prompt conclusion that a young asthenope is not hyperopic because he at first rejects plus glasses in functional examination, or even accepts weak minus ones, is wrong.

**A HAND-BOOK OF OBSTETRIC NURSING.** For Nurses, Students and Mothers. Comprising the course of instruction in obstetric nursing given to the pupils of the Training School for Nurses connected with the Woman's Hospital of Philadelphia. By Anna M. Fullerton, M. D., Physician in charge of, and Obstetrician, Gynecologist and Surgeon to, the Woman's Hospital of Philadelphia, etc. Fourth revised edition. Illustrated. Price, \$1.00. Philadelphia: P. Blakiston, Son & Co. 1895.

The fact that the little work before us has gone through four editions is of itself sufficient evidence that it has a certain sphere of usefulness, which it has filled to a great extent, and we can cordially recommend it to the class of readers for which it is intended.

**OBSTETRICAL POCKET-PHANTOM.** By Dr. K. Shibata. Translated by A. Howard-Audenried, M. D. P. Blakiston, Son & Co. Philadelphia, 1895. Price \$1.00.

This is an ingenious little device, which consists of a cardboard pelvis, through which a jointed cardboard fetus may be made to pass in imitation of the various stages of labor, and thus give the student a fair representation of the real state of affairs. It was devised by Dr. Shibata, a Japanese student in Professor Winckel's clinic in Munich, and was well enough thought of by the latter to induce him to write the preface to the German edition. We have no doubt that it may help many an American student to transform an indistinct mental image into one which conforms more closely to nature.

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#### REPRINTS, ETC., RECEIVED.

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**How to Disinfect.** By C. T. Kingzett, F. I. C., F. C. S.

**Troches.** By William T. Cathell, M. D., of Baltimore. Reprint from the *Maryland Medical Journal*.

**Surgical Treatment of Laryngeal Tuberculosis.** By J. W. Gleitsmann, M. D. Reprint from the *New York Medical Journal*.

**Hyperthermy in a Man up to 148° F. (64.4° C.).** By A. Jacobi, M. D., of New York. Reprint from the *Transactions of the Association of American Physicians*.

**State Provision for Epileptics.** By William Francis Drewry, M. D., of Petersburg, Va. Reprint from the *Transactions of the Medical Society of Virginia*.

#### Current Editorial Comment.

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##### ROENTGEN'S DISCOVERY.

*American Medico-Surgical Bulletin.*

THE discovery is certain to be tested and developed to the utmost; for this country, as well as England, teems with enthusiastic and wealthy amateur photographers of ability, who will eagerly embrace this opportunity for experimenting with a new and startling method of human portraiture.

##### MEDICAL FRAUDS.

*Texas Health Journal.*

IT is said that a drowning man will catch at a straw, and so it is with many of the afflicted who have been told by their honest family physician that they are suffering with probably an incurable disease, yet they still cling to hope and become the easy victims of the soulless advertising scamp, who proclaims that he has the power to heal all the ills to which human flesh is heir.

##### DIAGNOSIS OF DIPHTHERIA.

*Medical Record.*

WE notice that some of our contemporaries are speaking contemptuously of the culture tube as a method of diagnosis in diphtheria, and some of the more foolish are intimating that we will soon do away with microbes and go back to the good old style. It is true that some modifications have been made in the method by which the bacteriological diagnosis of diphtheria is made, but the value of the method is none the less great.

##### WHAT SHALL WE READ?

*North American Practitioner.*

IT becomes a serious question with every active medical practitioner as to the best method by which, with the limited time at his command, he may keep in touch with the rapid advances now being made in every department of his profession. While standard works are and will be essential to a well filled library for purposes of reference to well established and permanent truths, it hardly falls within the possibilities of the average practitioner to cumber his shelves with the successive editions of any standard work, and yet this must be done or he will fail to compass the advances which each revision of such a work must indicate.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### INJURIES OF THE EYEBALL.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
JANUARY 7, 1896.

By *W. H. Wilmer, M. D.*,  
Washington, D. C.

INJURIES of the eye are frequently among the various emergency cases that every physician, sooner or later, is called upon to treat. Without further prelude, therefore, I will present for your consideration tonight some points in the diagnosis, treatment and prognosis of these injuries, together with a report of a few cases.

I will not attempt to go into the literature of the subject at all, but will speak from my personal experience merely, and will report from my own case-book.

CASE I. A boy of about twelve years of age was struck on the eyeball, three mm. to the temporal side of the cornea, by a rebounding ball from a Flobert rifle. The ball pierced the conjunctiva but not the tough sclera, and dissected its way back between these two coats to the equator of the globe. In the interior of the eye, there was a slight rupture of the choroid corresponding to the site of the external injury and there was also some blood in the vitreous. S.— $\frac{2}{3}$ .

The foreign body was removed through an incision in the conjunctiva, which was afterwards united by a suture, atropia instilled, and an antiseptic bandage applied. Three months later, all the blood in the vitreous was absorbed and the sight was normal.

CASE II. W. L. K., aged 17, came to my office July 14, 1891, suffering agony with his right eye. He stated that two days before, he and several companions were playing ball with a glass bottle. The bottle was struck by a stick which drove a splinter of glass into his right eye. It pierced the cornea at a point midway between the center and the temporal side of the circumference, and buried itself in the periphery of the lens. I recognized that the glass was buried in the iris from the peculiar "pulled in" appearance presented by the iris at the site of the puncture, and also from an irregular reflection from the glass in certain lights.

When atropia was instilled, the pupil presented the irregular appearance shown in the figure. The following day I enlarged the original wound with a Graefe knife and pulled out the piece of glass with a pair of forceps. The splinter was about  $2\frac{1}{2} \times 1$  mm. The inflammatory symptoms soon subsided, leaving the eye perfectly quiet.

At present date, the sight amounts to not more than  $\frac{1}{200}$ , owing to a traumatic cataract. But this could be removed at any time with fair prospect of obtaining good sight.

CASE III. On April 7, 1892, I was

called in consultation to see a boy of about ten years of age. With some companions he had filed a fuse hole in a forty-four caliber brass shell. This they filled with powder and touched off. The shell struck the boy obliquely on the outer edge of the closed lid. When I saw him twenty hours after the accident, he was suffering very much with pain all through right side of the head. The vomiting after the accident had been constant. There was so much swelling and edema of the conjunctiva that the eye could not be entirely closed.

I found that none of the outer tunics had been ruptured, but the force of the blow had torn the iris away from its attachment for the space of three or four mm. in its outer, upper quadrant. Sight was only perception of light. Under the use of atropia, and constant ice applications, the inflammation soon subsided. After using atropia, the pupil presented the appearance of the figure. In this case, also, a traumatic cataract formed. But it could be removed, if desired, with prospect of sight.

CASE IV is quite unique. On October 15, 1890, as a young girl of fourteen years of age was leaving the Franklin School, she ran down the aisle with a new, sharp hat-pin in her hand. A mischievous companion tripped her by putting her foot in the way, and she fell, sticking the pin in her eye at the junction of the sclera and cornea on the nasal side. She pulled the pin out and came immediately to my office, so that I saw her a few minutes after the accident. The pupillary portion of the iris was wedged in the wound. Sight was reduced to  $\frac{1}{2}$  by reason of the blood in the vitreous.

I enlarged the wound slightly, replaced the iris, instilled a drop of  $\frac{1}{60}$  of a per cent. solution of eserine in the eye to prevent further prolapse of the iris, and put on a pressure bandage. The case improved rapidly and in six weeks the blood was so far absorbed that the sight was normal. The illustration shows the fundus of the injured eye as seen by the direct method eight months after the accident. The pin had evidently penetrated the whole depth of

the eye and punctured the retina and choroid on the inner side of the optic nerve. The patient has used her eyes steadily ever since her recovery and has not experienced any trouble.

CASE V. In order to indicate how blindness may be caused by a seemingly slight injury, I show merely a drawing that I made of the interior of a boy's eye six months after injury. The patient was struck in the eye with a piece of wire. He complained of very little pain and his parents attached very little importance to the injury. However, six months later, he complained of not seeing well with the eye that had been injured, and he was brought to me. As seen by the drawing, the choroid had been ruptured in the macular region, and the boy's sight in that eye amounted to very little more than perception of light.

CASE VI. The last case that I will cite shows that even the eye does not escape in the popular game of football. In January, 1895, a college boy consulted me about his right eye. He stated that two months before he had been struck in that eye by an elbow during a "scrimmage." The eye became somewhat inflamed but he did nothing for it beyond giving it a few days' rest. When the eye was examined, the sight was found to be less than  $\frac{2}{7}$ . The ophthalmoscope showed a rupture of the choroid just above the macula. He was advised to protect the eyes from the light by dark glasses and to give them absolute rest. In addition, he was to take small doses of potassium iodide. Eight months later, the exudation about the ruptured choroid was gone, and the sight normal.

In regard to the general treatment of eye injuries, it is most important to determine, first, whether there has been a penetration of the globe; and, second, whether there is a foreign body still in the eye. The history of the case will often assist materially in regard to the presence of a foreign body. In the case of a perforating wound that is not seen immediately upon injury, it is well to cut off all of the iris that projects. And the same procedure is even more urgent in regard to prolapsed vitreous.

The strictest antiseptic precautions should be used, atropia instilled, and an antiseptic bandage applied. In the case of a small wound of the sclera with projection of the vitreous, it is even well at times to use the actual cautery as a sterilizing agent. For the vitreous is most readily infected, offering as it does such an excellent natural culture medium for any germs that are introduced.

In regard to non-penetrating wounds, I would lay stress upon the early and free use of atropia, and of ice applications, especially in the oft-occurring injuries from soda water and ginger ale corks, etc.

In cases II and III, the early use of atropia would have prevented the iitic adhesions and allayed the iritis. In case IV, atropia was used after the first 24 hours. In case III, the ice applications were constantly used for 24 hours,

day and night, and then for several days, every alternate hour during the day.

In regard to prognosis, we cannot be too guarded. For a seemingly slight blow on the eye may cause a rupture of the choroid in the macular region, or a traumatic cataract later on. On the other hand, there might be a large rupture of the choroid in the equator of the eye, with a great deal of blood extravasated into the vitreous. The temporary blindness, in a case of this nature, would disappear with the absorption of the effused blood.

In the brief scope of a paper of this kind, it is impossible to give more than mere outlines, and I have, therefore, not touched upon the question of removal of eyes containing foreign bodies, sympathetic ophthalmia, many of the graver injuries, etc.

## URINARY CALCULI.

REMARKS AT THE CLINICAL SOCIETY OF MARYLAND, JANUARY 3, 1896.

*By Randolph Winslow, M. D.,*

Professor of Anatomy and Clinical Professor of Surgery, University of Maryland.

THIS is a subject which can well claim our attention. Not a case has been exhibited here for some time though it is an affection which is not very uncommon. In the normal condition of the urine certain salts are held in solution, but under abnormal conditions these salts become released and deposit concretions of greater or less size. When occurring in small granules these deposits bear the name of gravel and when of larger size are called stone. The deposition may occur in the tubules of the kidney, or in the pelvis, and passing down along the ureters give rise to what is known as nephritic colic. Sometimes instead of passing down into the bladder they become lodged in the pelvis and are known as kidney stones, or calculi.

The causes of the deposition of the salts are both local and constitutional, and among the latter are rheumatism, gout and some abnormal conditions of the digestive apparatus. It is probable

that most of the calculi which are found in the bladder have come down from the kidney and developed in the bladder. Where we have to deal with local conditions it will be found that they occur in the bladder as the result of foreign body, or obstructive disease.

There are quite a variety of calculi, but only three which claim our attention to any great extent. The uric acid, oxalate of lime, and the phosphatic calculi. The latter occur late in life and are generally the result of obstructive disease preventing the outflow of the urine from the bladder. I have here a number of calculi of various kinds.

The uric acid calculus is very hard, brown in color, occurs generally in young persons and is sometimes smooth, but not infrequently is covered with rough prickles and is very irritating to the bladder. The oxalate of lime calculus, known as the mulberry calculus, is likewise hard and very irritating.

The phosphatic calculus is usually white, or grayish-white, and soft, and is more liable to be irregular in size and shape than the others.

Calculi are usually single in the bladder, but not infrequently we find a number of them and I have here a beautiful little nest of them removed from a patient in this city on Thanksgiving day. All stones start with a nucleus of some kind, sometimes a bit of catheter, or straw, or some substance introduced into the bladder. They are found in all parts of the world, but in varying frequency in different places. In this country, for instance, it is rare in New England, but very frequent in Kentucky and Eastern North Carolina; why, I do not know. It is supposed in some regions to be caused by drinking hard water, but in some places where they do not use hard water we see it in great frequency. In some parts of India and China it is of enormous frequency. One surgeon in India having operated 739 times in three years, and as high as 50 times in one month.

There are various conditions of age, sex and race, which have relation to the production of stone. It occurs in young persons as the uric acid, or oxalate of lime calculus, and in older persons as the phosphatic. Whilst it occurs in women it is infrequent, but one case occurring in a woman out of 99 operated on by my father, the late Dr. Caleb Winslow. This is not difficult to understand when we remember the capacious bladder and wide urethra of the female. Certain races seem predisposed to the disease, the Caucasian most, and the negro least so.

The symptoms of vesical calculus are quite distinct. Among the first is that of frequent urination. There is also pain in many cases during the act of urinating and this pain is different from that of cystitis in that the latter is relieved when the bladder is empty, while the pain of calculus is increased. Pain is also often felt in the urethra near the meatus. The different varieties of stone are attended with very different degrees of pain, the rough ones giving most trouble. Amongst the symptoms

and effects of calculus is an interruption to the flow of urine. As the bladder collapses the stone acts as a ball-valve, and in the act of urinating the flow may be suddenly stopped. This occurs in a considerable number of cases, and the patient may, by assuming an abnormal position during the act, prevent its occurrence.

Bloody urine is not infrequently a symptom of calculus and pulling on the prepuce in small children is sometimes a sign. These symptoms are all suggestive, but do not make a certain diagnosis. Since the introduction of the cystoscope the stone can be seen. Usually the diagnosis is made by the introduction of a sound, by means of which the stone is felt, and in most cases a distinct click can be heard.

The treatment is divided into medical and surgical. The first amounts to little or nothing, as a rule, for it is doubtful whether a stone can be dissolved in the bladder. Under certain conditions where the individual is not a fit subject for operation medical treatment may relieve his symptoms to some extent, but where the patient is in condition for the removal of his concretions an operation should be done. The operative procedures are divided into two classes: First, those in which the stone is removed entire through an incision; and second, where the stone is crushed and removed in a comminuted state.

There are a number of methods of lithotomy, lateral or median, and recently there has been a revival of the operation of supra-pubic lithotomy. Sometime ago it was attempted to remove stone by crushing, the object being to introduce an instrument into the bladder and break up the stone so that it could be evacuated in small particles. This operation is known as litholapaxy. The best method to adopt is a point about which there is much difference of opinion. The recent statistics, which I have here, seem to prove that litholapaxy is the best operation for the great majority of cases.

The cases are grouped in three classes according to age, the first including from birth to puberty, the second from pu-

berty to middle life, and the third from middle to old age. In the first class 602 cases were subjected to perineal lithotomy and 19 died, percentage of mortality 3.1; 637 to supra-pubic operation, 84 died, mortality 13.1. This latter operation was thought to be peculiarly applicable to young children, as the bladder is then an abdominal and not a pelvic organ. In this class the operation of litholapaxy was performed 294 times and 5 died, a percentage of 1.7.

In the second group of 226 perineal lithotomies, 22 died, percentage 9.7; 159 supra-pubic lithotomies, 18 died, percentage 11.3; and 585 litholapaxies, 22 died, percentage 4.5. In the third group of 69 perineal operations, 13 died, percentage 19; 91 supra-pubic operations, 17 died, percentage 18; and of 581 operations by litholapaxy, 40 died, a percentage of 7.

In all three periods of life, then, the litholapaxy is the most favorable operation. We cannot always have a choice, for there are, of course, certain conditions which will demand one or the other of these methods of treatment. It does not seem to me that elderly persons with obstructive disease of the bladder are proper subjects for litholapaxy, although the modern statistics seem to

indicate it. My predilection is for supra-pubic lithotomy. In cases where there is a large number of stones they may not all be found and crushed. I had an experience with this operation which was very unpleasant. I removed this stone, by lithotomy, from a man sixty years of age. He did well after the operation, but subsequently his symptoms returned and I detected another stone in the bladder. He did not want to be cut again and I undertook a litholapaxy. The operation was very bloody. He never secreted any urine afterwards, and soon died. I think if he had been cut by either operation he would not have died in that way. This is, of course, only conjecture.

The statistics are in favor of litholapaxy almost to the exclusion of the other operations. We have seen the pendulum, however, swinging back and forth and I think it will swing back here to a considerable extent. The mortality in cutting operations has been reduced very largely and I expect that with care it will be brought to a still lower point. If a supra-pubic operation is done you can put in the finger and explore the bladder and by the same operation it is possible to relieve an obstruction by cutting off a portion of the prostate.

**THE SIGNIFICANCE OF PLEURISY.**—Dr. Egbert Le Fevre, in an article on the significance of pleurisy, in the *Medical Record*, concludes as follows from his experience :

1. It is impossible for records or observations from any one source to settle the question of the proportion of tuberculous and non-tuberculous pleurisies. Different observers will arrive at various results, according to the character of the infectious material most prevalent in their localities. Figures will also be influenced by the occurrence of epidemics, and the surroundings and social status of the subjects observed.

2. That in pulmonary tuberculosis an intercurrent attack of pleurisy may be non-tuberculous.

3. That frequently an attack of acute pleurisy is the first intimation of a pre-

existing or latent pulmonary tuberculosis.

4. Since neither the onset of the pleurisy nor the character of the exudation presents any diagnostic etiological features, careful and repeated examinations should be made of the sputum for the tubercle bacilli.

5. As it is generally impossible at the onset to say what is the nature of an attack of pleurisy, and even if it is considered non-tuberculous, we should recognize the fact that the barriers which nature has placed against the introduction of infectious matter into the respiratory tract have been broken through or removed, and until these have been replaced and the normal resistance of the organism restored, it is necessary to guard the patient against all sources of infection.

## Society Reports.

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### THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.

MEETING HELD JANUARY 7, 1896.

*Dr. Kelley* presented a specimen of a FIBROMYOMA ENCIRCLING A PREGNANT UTERUS containing a two months' fetus. History. When he first saw the patient he found a small tumor reaching just above the pubes; this he thought was the result of a pelvic peritonitis. The abdomen was opened, but as the uterus looked as if it was pregnant, the operation was discontinued and the abdomen closed. Six months after this time the patient was again examined; the tumor had not grown any.

Two months after this time the patient was again examined and the tumor was found enlarged very much; pregnancy was diagnosed, but denied by the patient. Finally she was prevailed upon to submit to an operation, as it was shown to her that the existence of some abnormal growth in conjunction with the pregnant uterus rendered her chances of recovery without an operation very doubtful. The operation of hysterectomy by Baer's method was done, and the specimen presented was the result. The second specimen by Dr. Kelley was a submucous fibroid of the uterus removed without an anesthetic.

*Dr. Richardson* cited a case of perichondritis of the cricoid cartilage as a sequel of typhoid fever. Tracheotomy was performed on account of stenosis of the larynx. The larynx is completely closed. The patient was a white male, aged 24 years.

*Dr. Sprigg* thought Dr. Kelley is to be congratulated on the fact that he operated upon the woman when he did, on account of the impossibility of her either going on to term without danger to her life, or being successfully delivered if she did. These cases of fibroid growths of the uterus need watching, and if they show any tendency to increase should be removed, particularly if there is any prospect of the patient becoming pregnant.

*Dr. Snyder* asked if there was much

hemorrhage after removing the submucous fibroid. Dr. Kelley said there was more before than after the operation.

*Dr. Van Rensselaer* asked Dr. Richardson, in reference to his case of laryngeal stenosis, what was the prospect for the man. Dr. Richardson replied that until a tube could be introduced into the larynx he would have to breathe by means of the tracheal tube. When a tube is passed into the larynx one of larger caliber can be introduced each day, so that a graduated scale may be observed until the larynx is opened to its normal caliber. He thought that in about two or three weeks the tracheal tube used in the tracheotomy could be dispensed with. At present there is absolutely no air passing through the larynx.

*Dr. Wilmer* read the paper of the evening entitled INJURIES OF THE EYEBALL. (See page 343.)

*Dr. Clarke* opened the discussion by saying that the paper of the evening was a clinical one and in keeping with the name of our society. In any injury of the eye it is well to warn the patient that sympathetic irritation is to be expected. Foreign bodies in eyes cannot always be discovered, and some patients come to you with the idea that there are foreign bodies in the eye, but none can be found. He would like to have Dr. Wilmer's opinion on the use of the magnet in removing pieces of steel from the eye.

Atropia is valuable in perforating wounds with prolapsus of the iris, if we can replace the iris, but if we cannot, amputation is indicated and eserine is better. Putting the eye at perfect rest with atropia is in conformity with the idea of the general surgeon to put at rest an injured member. He regretted that he could not make a more systematic and connected talk in the discussion of the paper.

*Dr. Sprigg* said the general practitioner is liable to be called upon to treat injuries of the eye and it is well to know what is to be done immediately, so that valuable time is not lost. He cited several cases of eye injuries, one in particular in which a splinter of wood 3 $\frac{1}{4}$

inches long and measuring  $\frac{3}{16}$  of an inch in diameter at its base was jabbed into the orbital cavity, and after its extraction the eye was uninjured.

*Dr. Glazebrook* said it was remarkable what a severe injury an eye will stand, and what an amount of trouble can arise from apparently slight injury. He wishes that he had heard such a paper as Dr. Wilmer's when he was in a hospital at Bethlehem, Pa., situated in a mining region, and many cases of eye injuries were brought to him. He cited several cases of remarkable injuries to eyes seen in this hospital. There are one or two questions relative to minor injuries to eyes worth considering.

Some cases of red-hot cinders in eyes, some imbedded deeply, have come under his observation. Was it wise or not to remove them immediately or let them remain some time? How late is one likely to find cataract from contusions of the eye?

*Dr. Wilmer*, in closing, said as to the time of appearance of cataract after traumatism, sharp bodies piercing the eye cause immediate cataract, but in contusions the lens becomes gradually clouded; in a few hours to four weeks it may be very slightly cloudy, three months more apparently cloudy, six months strongly clouded. In the removal of cinders and bits of steel an excellent plan is to use a 2 per cent. solution of florescine, which causes a brilliant green to suffuse the eye, and the foreign body shows out black so that it can be distinctly seen.

The electro-magnet in some cases acts beautifully. Bits of steel can be removed nicely, but if the vitreous once becomes affected nothing will save it. Sympathetic ophthalmia we must be very chary about, not removing too quickly. Florescine solution lasts but a few hours.

R. T. HOLDEN, M. D.,  
Secretary.

CAMPHOR FOR ETHER COLLAPSE.—One part camphor to ten parts olive oil is effective when used hypodermically in ether collapse. One grain of camphor may be given.

## CLINICAL SOCIETY OF MARYLAND.

MEETING HELD JANUARY 3, 1896.

THE 316th regular meeting of the Clinical Society of Maryland was called to order by the President, Dr. J. M. Hundley.

*Dr. Randolph Winslow* made some remarks on URINARY CALCULI. (See page 345.)

*Dr. J. M. T. Finney*: Dr. Winslow has pretty well covered the ground and I shall say but a few words, and that in regard to the treatment of this trouble. Like Dr. Winslow, I am inclined away from the operation of litholapaxy. During my student days and residence in a Boston hospital I had the opportunity of seeing Dr. Bigelow, who has done most for this operation, perform it, and also a number of his pupils, so that while I can not speak from experience in crushing stones, I have seen it done as it should be. I must say it is an interesting operation to watch, but one that struck me as being attended by more dangers than one would imagine from the statistics or from seeing one of these skilled operators perform it.

There are so many things that may happen; rupture of the bladder I have seen in one case; injury to the urethra being another; and in another, a thing that may not happen at present with the new instrument, but which did happen, the blades of the instrument became caught in the bladder and it was after many efforts and when the operator was on the point of doing a perineal section that the blades became disengaged. All of these things are objections to the operation. Statistics are in favor of it, but we all know how fallacious statistics are and in this instance this operation as a rule has been done upon the most favored and picked cases.

Children will stand almost anything and with them the conditions for this operation are most favorable, but to compare these with the supra-pubic operations, which are done upon the worst class of cases, those of large calculus or where there is prostatic trouble, and we all know where this has existed

for some time that the kidneys are prone to disease, is hardly fair. All these things have to be taken into consideration and they modify the statistics materially.

The disadvantages of the supra-pubic are greater than those of any other operation. You can see what you are doing, explore with the finger the entire cavity of the bladder, it is performed with great ease and if there is any foreign growth or obstruction to the outflow of the urine by an enlarged prostate you can remove the obstruction. One of the points most urged against the operation is the discomfort to the patient caused by the constant flow of the urine over the surface of the abdominal walls. Numerous efforts have been made to overcome this objection and lately they have met with considerable success. There is an apparatus devised by Dr. Bloodgood of the Johns Hopkins Hospital, which has worked very well so far and at my request he will show it to you this evening. The cases in which it has been used have been kept perfectly dry.

As to the question of sepsis, it is possible to have an inflammation about the womb, but with the care which should be exercised in every operation, doing as little violence to the tissues as necessary and keeping the surrounding parts clean by packing with gauze, the chances of infection are reduced to a minimum. The packing of the cavity in every direction about the bladder wound is all that I have to suggest concerning the operation. Sufficient attention has not been paid to that. The gauze should be left there until the wound heals by granulation. We have had no deaths attributed to the supra-pubic operation and I think the statistics are against it because the worst cases are the ones that have been submitted to it.

*Dr. J. D. Blake:* I endorse to a large extent what Dr. Finney has said, although I am inclined to the perineal operation. The choice of operations is, in my judgment, a matter of practice among surgeons. They become satisfied with their results and continue to do that operation which has given them

satisfactory results. I have seen Dr. Bigelow operate by litholapaxy in a way that we would call skillful and expert and as few of us could do and I am sure that when we have seen him do it we have seen the father of that method, but the length of time that even he consumes and the difficulties which he comes in contact with and which are more apt to bother us is apt to deter the most courageous.

I have only an experience in one single case and that was sufficient to deter me from any further effort in that direction. I crushed this stone and washed it out of the bladder and while I got away the stone after a long time, the operation lasting nearly two hours, the patient was very much shocked and came near dying. He rallied, however, and has had another stone, probably because I left some there, which I removed by the perineal operation. I have performed nineteen perineal operations, the youngest four months, and have never had a death.

Here are two very large stones which I removed from a small man. He was fifty-seven years of age and had suffered a great deal. You can imagine that in such a case the bladder was thickened, the prostate enlarged and the condition so far as asepsis is concerned was favorable. My opinion is that the perineal operation favors thorough drainage. You have it in the right direction and position and you relieve the kidneys which are usually involved. I have had one patient complain of what I suppose was an interference with the ejaculatory duct. He says that he does not accomplish the act of ejecting the seminal fluid until some time after the orgasm has passed off.

I agree with Dr. Finney to a certain extent that the supra-pubic operation has advantages which are not possessed by any other. I can, however, explore the bladder with my finger after the perineal operation. When you can have, as Dr. Finney has, all the advantages of skilled nurses in a hospital, etc., one is justified in doing an operation that he would not do in private practice where he must rely upon unskilled at-

tention. Under these latter circumstances I do not believe the supra-pubic operation would give the good results claimed. I believe the statistics are wrong.

My opinion is that nearly all the supra-pubic operations are done in hospitals, whereas the perineal ones are done promiscuously. We all remember the good results attained by the Smiths, and they did almost exclusively the perineal operation. Dr. Alan P. Smith operated eighty or ninety times without a single fatal case and most of them were in private practice. As to the removal of a portion of the prostate I should think it a serious thing for the patient, as you have there a source of infection and right where it can not be relieved with the hole above as well as if you had the hole below. Where the third lobe is bulging through there will be no necessity of removing it after the contraction which follows the removal of the source of trouble. I believe that the pendulum is swinging and that it will swing towards the perineal operation as the one for general use.

*Dr. J. C. Bloodgood:* I have here a supra-pubic drainage apparatus which was devised first for cases in which it was necessary to have permanent drainage from the bladder at a point about the pubes. It consists of a tube to fit in the sinus and long enough to pass through the abdominal walls and into the bladder for half an inch, a bag to collect the urine and between the bag and tube a saucer-shaped piece to fit close up against the abdomen. It is held in place by a belt passed around the body. The stopper can be drawn from the tube and urination take place as usual. The apparatus may be applied and the wearer go about just as other men do. It may be made of any material, hard rubber, silver or aluminum.

After establishing its success as a permanent drainage it occurred to me that we might use it immediately after an operation and thus prevent any leakage of urine and keep the wound absolutely dry. We have used it in this way with success. It seems to me this apparatus will absolutely prevent any infection of

the wound after the supra-pubic operation and I agree with Dr. Blake that the hospital is the proper place for this operation. In all of our cases (about thirty in the last three years) we have had but one death and in that case there was an existing pyelo-nephritis.

With an apparatus like this, one might prefer the supra-pubic operation to expression. We meet with some cases which are not relieved by expression. We have had two cases in which supra-pubic operation had to be done anyway because the patient could not wait for the prostate to atrophy. We have had some cases, too, that demonstrated to us that the sooner one overcomes the obstruction the better for the ureters.

*Dr. Randolph Winslow:* The statistics I reported are the latest known, taken from Dennis' new volume of Surgery, and are practically the same as those given in the International Encyclopedia of Surgery just out and edited by Ashhurst. My personal preference is, as I have said, favorable to a cutting operation.

Dr. Blake spoke of exploring the bladder with his finger through the perineum. His finger must be longer than mine. It is hard to get a three-inch finger through four or five inches of perineum and do much exploring beyond.

The Society then adjourned.

H. O. REIK, M. D.,  
Secretary.

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## COLLEGE OF PHYSICIANS OF PHILADELPHIA.

### SECTION ON OPHTHALMOLOGY.

MEETING HELD NOVEMBER 19, 1895.

A STATED meeting of the Section on Ophthalmology was held in the Lower Hall, College of Physicians, on November 19, 1895, Dr. Wm. F. Norris, Chairman, presiding. Present: Drs. Geo. Fales Baker, J. M. Da Costa, Cleeman, Eshner, Fenton, Fribis, Goodman, J. H. Grove, Hansell, Jackson, Leidy, Longaker, Wm. F. Norris, Oliver, Ring, Jno. M. Taylor, and Zentmayer, Fellows of the College, and Drs. Bromley, Cassel,

Mellor, Moorhead, Schneideman, and S. Lewis Ziegler as guests.

*Lr. Edward Jackson* exhibited a Binocular Lens for examination of the eye by oblique illumination. The speaker stated that he had been experimenting with such lenses for more than two years, and had at last obtained one made from a single piece of glass which gave a true stereoscopic image with little or no distortion.

*Dr. S. Lewis Ziegler* showed a case of Congenital Dislocation of the Crystalline Lens in a boy thirteen years old. Dr. Jackson reported a similar instance in which the lens had escaped into the anterior chamber, producing symptoms of secondary glaucoma; these symptoms disappeared immediately upon removal of the lens.

*Dr. Charles A. Oliver* gave a brief history of a case of a young girl seventeen years of age, in which a lens was successfully removed by a wire loop through an inferior section, the operation being performed by Dr. Norris. He also called attention to a traumatic case in which he had successfully removed a lens, restoring the patient's vision to almost full acuity, and mentioned that he fixed the lens into position so as not to fall back into the posterior chamber by spitting it through the corneal membrane by means of a narrow needle. In this case the section was made upward and the lens was removed by a loop without the loss of any vitreous, in spite of a widely dilated pupil.

*Dr. George Friebis* related the subsequent history of a double cataract extraction in a ninety-year-old patient in which the visual result in the left eye equaled almost full acuity and that of the right eye nearly one-half of normal. He stated that he considered these results remarkable in view of the fact that the optic discs were pallid and that the retinal vessels were contracted.

*Dr. Howard F. Hansell* cited four interesting cases of traumatism. The first case was that of a man who was struck with a broken bottle, cutting the left eyelid and producing a wound of one centimeter's length involving the corneo-scleral border and the upper ciliary re-

gions. The iris was prolapsed, the lens was dislocated under the conjunctiva, and there was an extensive loss of vitreous with profuse hemorrhage. The lens was removed and under antiseptic dressings and a pressure bandage, the wound healed and the prolapsed portion of the iris became glazed over. There were vitreous synechiaæ cicatrized in the corneal wound. Ciliary tenderness, diminished tension and absolute blindness were deemed of sufficient moment to enucleate the globe, which was done by a modified method from that recently proposed by Sukers, the four recti muscles being sutured together by a piece of catgut, which was passed through each muscle before division, thus including their distal ends and producing a bunch of tissue which would permit of more regular and extensive movement of an artificial eye. Contrary to expectation, no foreign body could be found in the organ. The second case was that of a boy who, whilst exploding a dynamite cap, had a piece enter the right eyeball in the lower inner quadrant, making a clean cut through the conjunctiva and sclerotic in the ciliary region. The piece of copper lodged in the ciliary body at a point opposite its entrance, where it could be readily seen through the uninjured lens with the ophthalmoscope after the pupil had been dilated with atropine. There were hemorrhagic extravasations into the anterior and vitreous chamber and into the sub-conjunctival tissue. Vision for distance was scarcely disturbed. In spite of increase of irritation signs, the parents positively refused to permit any attempt to extract the foreign substance. The third case was that of an Italian who received a wound in the right eye by the premature explosion of a dynamite cartridge. The accident occurred whilst the patient was engaged in blasting, about a month before he was seen. At the time of the first examination, an irregular, sharply outlined scar could be recognized about the center of the cornea. The anterior chamber was shallow, the iris was greatly contracted, and the pupil was filled with exudation. There was no light-perception, and intra-ocular ten-

sion equaled minus 2. The eyeball was injected and painful. Two days later it was enucleated, revealing the presence of a piece of copper which was found attached to the posterior capsule of the lens. The lens itself had been transformed into a semi-fluid, viscid mass.

The fourth case was seen within an hour after the patient; a machinist, had had a tool with a sharp cutting edge knocked out of his hand against his eye, making a clean cut through the cornea, the iris and the lens. A large portion of the vitreous had escaped. The iris, which was torn from nearly the whole circumference of its peripheral attachment and twisted on itself, protruded from the wound and rested on the prolapsed vitreous. The protruding portions of both the iris and vitreous were excised. The eye was washed with a bichloride solution and an antiseptic pressure bandage was applied.

In the discussion, Dr. Jackson referred to Leber's paper, in which the virulence of particles of copper in the eye was so prominently brought forth.

*Dr. G. Orem Ring* spoke of a case in a fourteen-year-old boy, which he had seen twenty-four hours after the accident. Six millimeters back of the corneo-scleral junction there was a wound, through which a probe could be passed and a metallic substance could be felt. The foreign body was removed and found to be a piece of gun-cap. The wound was pencilsed with a 1 to 500 strength of bichloride of mercury, and ice compresses were employed. The case went on to full recovery with a vision of  $\frac{2}{5}$ . He cited another case in a colored man whom he saw one hour after a cut in the cornea had been received. This iris was adherent, there was rapid swelling of the lens, and in thirty-six hours panophthalmitis was so pronounced that enucleation was rendered difficult. A piece of steel, broken from a hammer, was found lodged in the ciliary region.

*Dr. Friebis* detailed a brief account of a case that he had seen five years previously in which a seventeen-year-old lad had his right eyeball so ruptured through a large corneo-scleral wound by a piece of hot iron that nearly all of the vitreous

humor had escaped and the folds of the ciliary processes were exposed to view. Upon suturing the sclera and the cornea, the latter membrane immediately regained its luster. In two months' time, the interior of the eye had cleared itself sufficiently to allow the patient a vision of  $\frac{2}{5}$ , this being obtained with the correction of about a diopter and a half of astigmatism. One year ago the vision had risen to  $\frac{15}{xx}$  with a correcting lens of + S. 0.50 D.  $\infty$  + C. 1. D. ax.  $60^\circ$ . Tension was slightly minus. At present there is a normal acuity of vision with + C. 0.50 D. ax.  $90^\circ$ . The remarkable part of the case consists in the fact that the lens was not disturbed in any way in spite of the severe traumatism.

*Dr. Jackson* cited a case of cataract extraction in advanced diabetes that he had recently seen in Denver, Colorado, in which the immediate results were excellent up to the fifth day, when the patient complained that she had sudden loss of vision with severe pain. There was edema of the globe with slight hyperemia of the anterior segment. No trace of infection could be detected. Both edema and pain increased. The iris became inflamed and pus appeared in the anterior chamber. A week later, the patient complained of pain in the arm, and a diagnosis of thrombosis of the upper extremity was made. The patient died of cerebral thrombosis. The ocular symptoms were supposed to be dependent upon thrombosis of the choroidal veins.

*Dr. Oliver* exhibited a series of water-color sketches, made for him by Miss Margaretta Washington. They embrace several drawings of the ophthalmoscopic appearances of intense neuro-retinitis in supposed cerebral and cerebellar tumors; degeneration changes in the retina and optic nerve from descending neuritis in a case of basilar meningitis; retinal hemorrhage and blood extravasation into the vitreous in a case of supposed embolism of the central retinal artery; macular changes in a case of lightning stroke; the appearance of the optic nerve-head and surrounding retina in a case of hereditary retrobulbar neuritis;

and a remarkable retinal vessel distribution in a case of coloboma of the iris and choroid.

The meeting then went into Executive Session. Upon motion, adjourned.

CHARLES A. OLIVER, M. D.,  
Clerk of Section.

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THE MEDICAL AND SURGICAL  
SOCIETY OF BALTIMORE.

STATED MEETING THURSDAY, JANUARY 23, 1896.

AT this meeting the following officers were elected for the ensuing year: President, Dr. W. S. Gardner; Vice-President, Dr. R. G. Davis; Reporting and Recording Secretary, Dr. S. T. Roeder; Corresponding Secretary, Dr. C. F. Blake; Treasurer, Dr. W. H. Schwatka. This being the twenty-fifth anniversary of the Society, it was adjourned to the banquet hall and discussed a well-served menu at which the following toasts were responded to: "The Retiring President," Dr. J. William Funck; "The President," Dr. W. S. Gardner; "The Doctor," Dr. D. W. Cathell; "The Clergy," Dr. J. B. Schwatka; "The Orator," Dr. J. W. C. Cuddy; "Looking Backward," Dr. A. Friedenwald; "The Amiable Woman," Dr. J. D. Blake; "Our Health Commissioner," Dr. J. F. McShane.

Dr. E. M. Reid acted as toast master and presided in a humorous and entertaining manner. Songs were sung by Dr. Funck and Mr. William R. Hall. Violin solo by Dr. H. Baxley, Dr. H. G. Harryman, accompanist. Sixty members and their guests participated.

S. T. ROEDER, M. D.,  
Secretary.

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**SOLANUM CAROLINENSIS IN EPILEPSY.**  
—The drug which is commonly called horse-nettle has been used with decided success in epilepsy. It relieves the paroxysms of that disease and does not cause the unpleasant after-effects of the bromides. Ten to fifteen drops of the fluid extract is the ordinary dose, but as much as a teaspoonful may be given.

## Correspondence.

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### THE PASSING OF THE GARGLE.

ROCKVILLE, MD., Feb. 17, 1896.

Editor MARYLAND MEDICAL JOURNAL:

*Dear Sir* :—In your issue of the fifteenth of the present month, under the head of "Medical Progress," you publish an article entitled, "The Passing of the Gargle." If the gargle must be relegated to oblivion, the spray should follow, at least so far as it is intended to take the place of the inhalation of steam in the treatment of inflammation of the air passages.

The spray reaches little farther than the gargle, whilst steam can be made to permeate the remotest air vesicle, though the employment of the spray has the appearance of doing something for the patient. I have seen very little good resulting from the use of it. Steam should be immediately applied in every case of acute inflammation of the air passages—from a slight hoarseness to the most severe form of laryngeal diphtheria.

All the apparatus necessary for the inhalation of steam is a coal oil stove, a kettle filled not quite to the spout with boiling water, a paper tube about two feet long to convey the steam from the spout of the kettle to the mouth of the patient. With such an apparatus I have saved more than one life and have never failed to give relief. Even in fatal cases of laryngeal diphtheria I have given my patients temporary relief and enabled them to sleep comfortably for half an hour at a time. By means of steam the physician may convey any medicament he may see fit to employ.

Eighteen years ago I had under my care a man who seemed to be in the last stages of consumption and who was unable even to sit up in bed. This man, though he finally died of phthisis pulmonalis, was enabled not only to get out of bed but to attend to his business, that of tax collector, for several years, by the inhalation of steam charged with car-

bolic acid, tonics and stimulants being used at the same time.

Deeming it more important to call to mind the old remedies than to suggest new ones, I remain,

EDWARD ANDERSON, M. D.

## Medical Progress.

MALINGERING IN CHILDREN.—According to the *Lancet*, the typical schoolboy has long been known as a fairly skillful malingerer when occasion demands it, but his shamming is usually confined to the more homely complaints of headaches and toothaches, which are capable of rapid dispersion when the crisis which necessitated their presence is past. The children of Nassington—a village in Northamptonshire—however, go more carefully and deeply to work in order to avoid the toils of school. On account of the number of children who were kept from school because of a rash on their bodies, Dr. C. N. Elliott, the medical officer of health of that district, was asked to examine them with a view to finding out the nature of the strange disease. His report showed that the whole affair was a case of malingering. The children, about twenty-five in number, were suffering from no real disease, but in order to stay away from school they had rubbed their hands and arms with the juice of the plant called "Patty Spurge." The result of this was that a vesicular eruption appeared which in most of the cases resembled a herpetic eruption, but in some there were blisters as large as half-a-crown. As the children appear to be studying the physiological effects of plants a closer knowledge of the birch tree and its branches might possibly divert their energies into another channel or at any rate dull their keenness for practical botany.

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A SUGGESTION IN ETHER ADMINISTRATION.—Dr. David H. Ludlow of Denver, Colorado, says, in the *Philadelphia Polyclinic*, that it is an interesting question to what extent the objectionable features of ether anesthesia are to

be attributed, directly or reflexly, to its irritation of the mucous membrane, and how far, consequently, they can be lessened by appropriate means aimed at preventing such irritation.

When ether is mixed with twice its volume of a bland, light preparation of liquid petrolatum and thoroughly nebulized with a suitable atomizer, it is absolutely unirritating, and even with a much smaller proportion of oil is practically so. A little cocaine (the alkaloid) may, if desired, be dissolved in the ether before adding the oil, but it is unnecessary. The oil, by preventing the irritation (not merely cutting off the connection with the central nervous system, as the cocaine does), avoids not only immediate reflex disturbances, but all direct injury to the mucous membrane and also, consequently, the later reflexes which, with cocaine alone, are likely to be troublesome after the local anesthesia has passed off.

The writer has used a few puffs of the mixture from the atomizer directly into the nostrils, before administering ether in the usual way, with apparently happy results, the anesthetic being taken easily, with no stage of excitement and with practically none of the common annoyances incident to its use.

A more extended employment of the method will be necessary to demonstrate its value, but the experience had with it so far justifies at least the suggestion of its thorough trial.

\* \* \*

FRIEDLAENDER'S PNEUMO-BACILLUS.—Etienne (*British Medical Journal*) gives a general review of the diagnosis and occurrence of Friedländer's bacillus, and has collected from the literature the different diseases in which the bacillus plays a part, either as cause, or else as an almost invariable concomitant. It has been recognized in the following diseases: ozena, stomatitis aphthosa, purulent rhinitis, rhinoscleroma, purulent parotitis, dacryocystitis, keratitis, otitis media, phlegmonous suppuration, broncho-pneumonia, empyema, pericarditis, meningitis, angiocholitis, pyelo-nephritis, and in pyemic and septicemic diseases.

MARYLAND

## Medical Journal.

PUBLISHED WEEKLY.

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BALTIMORE, FEBRUARY 29, 1896.

PHYSICIANS are at one with sociologists in trying to better the world and help the helpless and dependent. Dr.

*Social Defectives.* R. M. Phelps, in the *Medical News*, in an article on the prevention of social defectives, thinks, as many others probably do, that it is better to apply prevention to the problem of our defective classes, rather than to let things go and then try to do some patching up later. He says that about 1 in every 170 persons is defective.

After discussing the subject from all sides, he says that the first part of our task is that we have laws to prevent the transmission of the more gross defectiveness; and secondly, we should enforce education to bring the people up to that point that they will appreciate these methods of prevention. Do not force weak and nervous children at school; teach them to avoid the great evils of drink and other forms of dissipation; tone up their physical being by the physician's aid.

In conclusion the author sums up those

to whom most peculiarly belongs the name defective:

"1. A gross form of mental feebleness can be produced by head-injuries or in later life by brain changes like those of hemorrhage or abscess of the brain, and in senile life atherosclerosis, atrophy and general senile recession.

"2. In very early life such causes as severe typhoid or scarlet fever can in a few cases produce permanent feebleness of mind, however, acting upon a predisposition.

"3. Under heredity we may have (a) one or both parents insane, imbecile, epileptic, paralytic, eccentric, hysterical, choreic, or with other nervous or mental defects, or (b) one parent may be syphilitic, consumptive, alcoholic, or Brightic, and the nervous system thus impaired will show an impaired nervous system in the children of varying type, or developing into defects the form of which seems largely a matter of seeming chance.

"Under headings one and two our preventive ideas do not very thoroughly apply, but these do not make up a very high per cent. of our total cases. The third class is that to which we may apply our effective study. We advocate, first, legal measures controlling or preventing the marriage of the grossly defective ones; secondly, hygienic and general education which shall hinder the development of the predisposed traits and help people to avoid the effects; and, thirdly, the education of the popular masses to sustain and support preventive measures as advocated.

"In conclusion, concerning legal measures, just a note. It has been said that all men are "free and equal," but the fallacy of this is now quite well known. We are not free to do that which will interfere with other's freedom or well-being, and the marriage of epileptics certainly does just this to the offspring. I feel that by such measures we strike at the root of the evils, while by nursing and liberating the defectives we merely try to bend and direct and make healthy the branches and often perpetuate the defectiveness. I cannot think that by multiplying words or by rhetorical effects I can add to these plain statements, which I hope are honestly, if too bluntly, stated. I therefore leave the subject with you."

The subject is well treated and is of a kind that should attract the attention of the profession, whose duty it is to aid in elevating the weak and dependent.

It should be a great source of congratulation to the citizens of Baltimore, to the medical profession and to *The City Health Officers*. friends of civil service reform that the Mayor of Baltimore has seen fit to reappoint Dr. McShane as Health Commissioner.

After an experience of about twenty years in the health office in which he has become familiar with smallpox, yellow fever, typhus fever and other diseases not ordinarily seen by the average physician, Dr. McShane, first as assistant and later as chief, has used this experience carefully and has studied these diseases in a way which must of necessity make him a better officer than any other applicant, and it is a great satisfaction in these days of spoils and patronage that a good man is kept where he deserves to be kept, politics and other things to the contrary. There is probably no one who has the good of the city at heart but who is glad to see Dr. McShane retained.

The assistant Health Commissioner is a new man to many. He is Dr. Edward S. Conlyn, a graduate of the Hahnemann College of Philadelphia in 1880, and is a member in good standing of the Maryland State Homoeopathic Medical Society. Dr. Conlyn is a brother of Mr. Conlyn of the well known firm of Croft and Conlyn, pharmacists, corner of Park Avenue and Madison Street, Baltimore. It was the desire to represent this branch of medicine that prompted Mayor Hooper to appoint Dr. Conlyn and it was done with that idea of fairness that permeates all his actions. The principles on which the two schools of medicine are supposed to differ can hardly play any part in the consideration of health matters.

These appointments have not yet been confirmed by the City Council, but those who have witnessed the Mayor's tenacity and persistency know that his wish will be the law, kickers and spoilsman notwithstanding. It is a pleasure to see the good appointments of the Mayor rise superior to the designs of these petty law-makers, men who own no property and pay no taxes and take no interest in the city's welfare beyond what they themselves can squeeze out of it.

The Mayor promised long ago that he would appoint no one as Health Commissioner who was objectionable to the medical profession and he has kept his word, and those

physicians who endorsed Dr. McShane and worked for his retention should show their further interest by congratulating the Mayor on his good work.

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THE recent gift of the brothers of the late Dr. Charles Frick should stimulate men who are in the profession to *Private Medical Libraries*. think of the Faculty Library and its needs. Every physician has a medical library, large or small, and almost every library, even the smallest, contains some books of value.

When a physician dies his estate is settled up and his property divided, the library is usually sold or scattered and brings little in proportion to what it cost or to its true value. As no one knows when death will come, physicians, young as well as old, should so arrange their affairs that their heirs will have a clear understanding of what disposition should be made of their books, instruments, etc.

Why should not every physician in the State who has no one to succeed him in the practice of his profession make a will bequeathing all his books to the Library of the Medical and Chirurgical Faculty? If several men who are not physicians give a large sum of money in commemoration of their brother's name, why should not physicians themselves who have used the library and who do use it and profit by the books and journals there, make some provision by which the library will inherit all or a part of their medical books?

The library board would gladly dedicate all such books to the persons so leaving them and in years to come as future physicians use the library they would read the names of the donors and would hold in veneration the generous physicians whose names would live in their gifts.

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THE communication in this issue and the note in a former number of the JOURNAL ON the Passing of the Gargle has attracted wide attention in the various journals. The gargle is effective to a very limited extent in the milder throat troubles, but its good effects are limited. The fault is that few physicians show the patient how to use a gargle and how to get it to the back part of the throat without danger of strangling or swallowing the usually nauseous mixture.

## Medical Items.

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We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending February 22, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		30
Phthisis Pulmonalis.....		22
Measles.....	56	2
Whooping Cough.....	5	1
Pseudo-membranous Croup and Diphtheria. }	22	9
Mumps.....	1	
Scarlet fever.....	15	
Varioloid.....		
Varicella.....	5	
Typhoid fever.....	1	1

New York City has 3,000 doctors, 600 of whom are native Americans.

Dr. Edward E. Gibbons has moved his offices to 1102 West Lafayette Avenue.

The City Health Department will probably have a laboratory connected with it soon.

Dr. Robert C. Rasin has removed to 405 Park Avenue; his residence is 809 North Eutaw Street.

The Woman's Medical College of Baltimore celebrated its fourteenth anniversary last Monday night.

The daily papers announce the death of Dr. E. W. Canfield, an old physician of Cumberland, Maryland.

The *Ladies' Home Journal* announces that it will no longer receive advertisements of medical preparations. Such action can not be too highly commended.

According to the daily press, Dr. William Lee Howard of Baltimore has been elected Vice-President of the Medico-Legal Society of New York, and also Chairman of the Committee on Psychology.

Dr. Joseph Jones, Surgeon General of the United Confederate Veterans, ex-president of the Louisiana Board of Health, and one of the leading physicians in the South, died last week at New Orleans, aged sixty-three.

Sir George Humphry has collected information regarding 45 centenarians, of whom

only 12 were total abstainers, while 30 were moderate drinkers, and 3 were heavy drinkers. Of 689 persons between eighty and one hundred years of age, as given in Sir George Humphry's tables, only a fraction over twelve per cent. were abstainers, while nearly nine per cent. were heavy drinkers.

Governor Lowndes has sent in the following appointments: State Board of Health, Dr. Dekrafft of Dorchester county; Henry Brauns, C. E., of Baltimore city; Dr. John Morris of Baltimore city. Coroners, Eastern District, Dr. William T. Riley; Northeastern, Dr. Elwood Huggins; Western, Dr. Edward Grompler; Northwestern, Dr. John R. Abercrombie; Central, Chas. L. Buddenbohn; Southern, Dr. Edwin Geer; Southwestern, Dr. George D. Mudd. State Vaccine Agent: Dr. J. Fussel Martenet.

At the last meeting of the British Medical Temperance Association a paper was read by Dr. C. R. Drysdale on Therapeutics without Alcohol. He took the position that alcohol was of very little use, if any, in the treatment of disease. Sir B. W. Richardson, who presided, said that, in conjunction with the late Dr. Farr, he had found that alcohol caused more deaths in England and Wales than consumption. His experience at the Temperance Hospital had been most satisfactory. The discussion was continued by Dr. Norman Kerr, Dr. Hazel, Dr. Paramore and Dr. Ridge, and a vote of thanks was unanimously accorded to Dr. Drysdale.

Mayor Hooper has made the following appointments: Commissioner of Health and Registrar of Vital Statistics, Dr. James F. McShane; Assistant Commissioner of Health, Dr. Edward S. Conlyn; Quarantine Hospital Physician, Dr. Sidney O. Heiskell. Vaccine Physicians: Second Ward, Dr. John H. Rehberger; Fourth Ward, Dr. Jacob H. Mitnick; Tenth Ward, Dr. Robert J. Murray; Twelfth Ward, Dr. Morris C. Robins; Thirteenth Ward, Dr. William Wolf; Fourteenth Ward, Dr. John G. Jeffers; Seventeenth Ward, Dr. Conrad P. Strauss; Nineteenth Ward, Dr. Charles H. Dixon; Twenty-first Ward, Dr. J. Burch Joyce; Twenty-second Ward, Dr. Walton Bolgiano. The salary of each is \$300. Sanitary Inspectors: Twenty-first Ward, Drs. Lewis F. Frey and Lewis H. Gundry; Twenty-second Ward, Drs. Harry C. Algire and George H. Everhart.

## WASHINGTON NOTES.

From the Health Office we learn that there has been an increase in the mortality during the past week. There have been 112 deaths, with an annual rate of 21.3. For the corresponding period of last year the deaths numbered 103, with a rate of 19.8. Acute lung diseases, principally pneumonia, are the principal cause of death. There have been five fatal cases of grippe, indicating an increase in the number of cases of this disease. Twelve deaths from heart disease and two from typhoid fever were reported. Twenty premises, at the close of the week, were placarded for diphtheria and nineteen for scarlet fever. During the week, there were two deaths from diphtheria, twenty-one cases discharged cured and eleven new cases were reported; whereas, of scarlet fever, four new cases were reported and twelve were discharged cured. There were three deaths from measles but there is no compulsory report of this disease, so it is impossible to tell how many cases of this disease existed. Of the total deaths, twenty-one occurred in hospitals and the coroner certified to six.

The Clinico-Pathological Society held its regular meeting on Tuesday, February 18, 1896, the President, Dr. H. B. Deale, in the chair. Dr. L. K. Beatty read the paper of the evening, entitled "Colles Fracture." The discussion was opened by Dr. E. L. Tompkins and joined in by Drs. John Van Rensselaer and W. M. Sprigg.

The Medical Society of the District of Columbia held its regular weekly meeting on Wednesday, February 19, the President, Dr. S. C. Busey, in the chair. The programme was very interesting and was carried out as follows: Dr. McGuire, Freaks as Pertaining to Diseases of the Skin (with illustrations). Dr. Kerr, Supra-malleolar Osteotomy for Deformity following Potts' Fracture. Dr. Acker, Tumor of the Heart and Lungs; case and specimen. Dr. J. Ford Thompson, Pathological Specimens.

The regular meeting of the Washington Obstetrical and Gynecological Society was held on Friday, February 21, the President, Dr. G. Byrd Harrison, in the chair. Dr. J. Taber Johnson presented a specimen of Hysterectomy for Cancer, followed by Suppression of Urine. The patient passed urine several times after the operation, so the doctor

did not think the ureters were tied. The specimen was discussed by Drs. H. L. E. Johnson, I. S. Stone and J. Wesley Bovée. Dr. J. F. Scott read the essay of the evening entitled, "Gonorrhea in Women." The discussion was opened by Dr. I. S. Stone, who was followed by Dr. T. Ritchie Stone, a visitor, who had numerous photographs of the gonococcus and also a microscope, with several slides, showing the gonococcus. Others also joined in the discussion.

The bill for the incorporation of the Post-Graduate School of Medicine of the District of Columbia, which was introduced some time since in the House and Senate, has passed both of those bodies and has been signed by the President.

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Book Reviews.

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PREGNANCY, LABOR, AND THE PUERPERAL STATE. By Egbert H. Grandin, M. D., Consulting Surgeon to the New York Maternity Hospital, etc.; and George W. Jarman, M. D., Obstetric Surgeon to the New York Maternity Hospital, etc. Illustrated with Forty-one Original Full-page Photographic Plates from Nature. Royal Octavo, Pages viii, 261. Cloth, \$2.50 net. Philadelphia: The F. A. Davis Co. 1895.

One rarely meets with a book which offers so slight a claim for commendation and so great a need for criticism as does the volume before us. It presents throughout marked evidences of haste in its preparation, which is shown by the omission of many important details and the extraordinarily poor style in which it is written. One can scarcely read several pages without meeting with phrases and expressions which violate every rule of good diction. For example, we may find such a sentence as the following, page 82, "Under circumstances when deep palpation is not impossible, owing to great adipose in the abdominal wall, or excessive amount of liquor amnii," etc. We may also find a normal, uncomplicated labor or puerperium described as "smooth," and numerous similar expressions.

There is nothing in the text which is not found in the usual text-books on obstetrics, and apparently its chief claim for existence is based upon the fact that it is "illustrated with forty-one original full-page photographic plates from nature." Some of the plates are really good; the majority either

show nothing or are entirely superfluous; while a considerable number give evidence that the authors could not resist the temptation, which appears to so assail many at the present time, of exhibiting their likenesses as often as possible to the long-suffering profession.

Actual count shows that at least 21 out of the 41 plates are practically useless. For example, plate 8 gives a "cabinet" likeness of a woman suffering from "melancholia complicating pregnancy." Plates 15, 16, 17, 18 are full-page illustrations representing one of the authors auscultating the fetal heart in the various presentations of the fetus. Plate 27 presents the instructive sight of an assistant wiping off the vestibule with a piece of cotton previous to catheterizing the patient. Plate 33 represents the authors and two assistants "clamping the cord and cutting between the clamps." And in plate 38 we are edified by seeing the authors and three assistants "washing the eyes of the fetus immediately after delivery."

Lack of space forbids our criticizing the illustrations in detail, but the few, which we have mentioned, will serve to represent the character of many others. In conclusion, we might express our surprise that two such able men as the authors could unite to produce so poor a work.

#### REPRINTS, ETC., RECEIVED.

An Essay on Diphtheria and its Specific Treatment. By John Pernat, M. D., Evansville.

Three Cases of Enucleation of the Eye, with Remarks. By Leartus Connor, A. B., M. D., Detroit. Reprint from *Harper Hospital Bulletin*.

Studies on the Lesions Produced by the Action of Certain Poisons on the Nerve-Cells. By Henry J. Berkley, M. D., Baltimore. Reprint from the *Medical News*.

A Case of Hydrosalpinx; its Removal of the Right Tube and Ovary without Rupture of Sac. By Hunter Robb, M. D. Reprint from *Western Reserve Medical Journal*.

Guaiacol in the Treatment of Typhoid Fever in Children. By Adolph Koenig, M. D., Pittsburgh, Pa. Reprint from the *Journal of the American Medical Association*.

#### Current Editorial Comment.

##### PROPRIETY VS. DECENCY.

*The Medical and Surgical Reporter.*

IN New York a certain society of women—presumably of the new kind, though with some very old-fashioned and disreputable notions—is endeavoring to secure State legislation providing that only married physicians be employed as assistants in insane asylums where women are confined. It trusts that the good sense of legislators will check the effort to enact such a bill. Prudishness rests on a substratum of nastiness and the present movement deserves the hearty condemnation of the medical profession as of all clean-minded men and women, for a variety of reasons.

##### THE PLEA OF INSANITY.

*Langsdale's Lancet.*

THIS subject has afforded a text for many able papers from the pens of scientific writers and called forth animated discussions in medical and medico-legal societies for years. Yet, more and more frequent has become the plea of insanity as a defense when a person has committed murder or some other heinous crime. The extent to which this plea has been carried and the success it has met with has become a cause for gravest alarm. Hardly a week passes that we do not read in the daily papers of a cold-blooded murder where the statement is made that the attorneys have not, as yet, decided whether to enter a plea of self-defence or insanity.

##### INTELLIGIBLE TITLES.

*Fort Wayne Medical Magazine.*

IT may be stated as axiomatic that published articles are of value just as far as they are accessible to the profession. To this end—that is to increase their accessibility—since the mass of periodical medical literature of today far exceeds the reading ability, to say nothing of opportunities of even the most industrious among us, various indices have been made that enable those who wish to utilize the studies and observations of others to do so by selecting for study such papers as are shown by their titles to be pertinent. The value of these indices, without which the exhaustive dissertations of the period would be out of the question, depends entirely upon the clearness of the titles of the papers listed.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### APHONIA AND DYSPHONIA AS SYMPTOMS OF LARYNGEAL DISEASE.

By S. K. Merrick, M. D.,

Professor of Diseases of the Nose, Throat and Chest, Baltimore Medical College.

UNTIL Señor Manual Garcia of London, in 1855, practiced successfully auto-laryngoscopy and thus opened the way for Türk and Czermak of Vienna to successfully use the laryngoscope on their patients, aphonia and dysphonia with certain associated symptoms were the only guides to the practitioner in making a diagnosis in laryngeal disease. While a large number of medical men every year are acquiring skill in the use of the laryngoscope and still a larger number are learning something about the practical use of it, yet the majority of the profession probably make their diagnoses in most cases without it in laryngeal disease at the present day.

As soon as the symptoms become urgent the specialist's services are brought into requisition, but often precious time has been lost by placing too much reliance upon the symptom of vocal impairment, which may not convey from the beginning an adequate idea of the gravity of the disease and which may not in other cases progress *pari passu* with the morbid process. In view of these facts I have thought that a consideration of the advantages and disadvantages growing out of the exclusive reliance upon dysphonia or aphonia in the diagnosis of laryngeal disease might not be uninteresting to the Society.

In order to get at the diagnostic value of vocal impairment, whether complete or partial, it will be most convenient to take up in groups the diseases attended with either complete or partial loss of voice. It is not the purpose of this paper to consider every possible diseased condition of the larynx accompanied by aphonia or dysphonia, but those sufficiently frequent to be of practical importance.

The various forms of laryngitis being probably more frequently associated with loss or impairment of voice than any other group of laryngeal affections, will take first rank. They certainly outnumber the cases of any other group. Under this heading we have acute, subacute and chronic simple laryngitis, tubercular laryngitis and syphilitic laryngitis. We may have in acute laryngitis aphonia or dysphonia. In this disease the practitioner rightly relies on this symptom as pathognomonic. Taken in connection with a coryza, either antedating it by a few hours or days or co-existent with the sudden hoarseness, little doubt is left as to the diagnosis. In this affection, then, aphonia or dysphonia, as the case may be, has a definite diagnostic value. In the sub-acute or chronic varieties, however, these symptoms are less definite. They indicate

with more or less definiteness that the inflammatory thickening or swelling has not subsided, when the patient has been under observation from the onset, but should the case come under observation for the first time some weeks or perhaps months after the acute stage, the symptom of vocal impairment will be no guide in making an exact diagnosis.

Any one or more of a number of changes may have taken place in this time which directly result from acute laryngitis and which may impair the functional activity of the cords for life. Manifestly, to rely on the aphonia, or dysphonia, as an adequate diagnostic index is not only bad practice, but is morally wrong and fraught with great risk to the patient in this affection.

The following are a few of the most common changes which take place in sub-acute or chronic laryngitis, every one of which requires the skill of the specialist to cure—with failure even then sometimes—thickening of the cords, infiltration or swelling of the ventricular bands, thickening of the inter-arytenoid fold, interfering with proper approximation of the cords and often resulting in dysphonia. Sometimes penetration of the inflammatory process into the intrinsic muscles of the larynx takes place, resulting in paresis. Hoarseness, or loss of voice, due to acute laryngitis, which does not recover in ten days or two weeks at least, is becoming sub-acute and no case should go beyond this time without a laryngoscopic examination.

In tubercular laryngitis, the dysphonia in the primary stage differs in no way from that attendant upon chronic laryngitis, and even when the bacillus tuberculosis is found in the sputum it does not prove the existence of a tubercular process in the larynx. It is not an uncommon phenomenon to have a catarrhal laryngitis present in pulmonary tuberculosis—the sputum from the lungs being filled with the bacilli and passing over the mucous membrane of the larynx without infecting it. This is a fact with which every laryngologist is familiar. In the late stages of tubercular laryngitis the dysphonia giv-

ing place to aphonia as the local condition becomes progressively worse; the vocal impairment then is a very reliable symptom, but its definite significance is only made manifest after the time when remedial measures even in the hand of a specialist are likely to prove successful. The only cases of tubercular laryngitis which the most skillful laryngologist can hope to cure are those cases which come under his observation at a time when the diseased parts are so circumscribed that they may be removed surgically, or destroyed by cauterization.

From the foregoing it is seen that the symptoms of dysphonia, or aphonia, are only reliable diagnostic indices of laryngeal tuberculosis when the patient has crossed the danger line. In pulmonary tuberculosis the voice occasionally becomes dysphonic or aphonic and a laryngoscopic examination fails to discover any disease in the larynx. Sir Morell Mackenzie believed this phenomenon due to loss of power in the expiratory muscles and not to degenerative changes (as some believe) in the muscles or nerves of the larynx. The vocal impairment here might be very misleading without the aid of the laryngoscope.

In syphilitic laryngitis we encounter many morbid changes in the laryngeal structures, most of which are attended with dysphonia and not a few with aphonia. The other specific lesions which may be present taken in connection with these symptoms of vocal impairment will make the diagnosis moderately certain, but when no other lesions are present and reliance is to be placed alone on the dysphonia or aphonia for a diagnosis their significance is very indefinite indeed. When these lesions take place ten, twenty, or even thirty years after the primary sore, as they often do, and the practitioner often ignorant of the patient's history, the unreliability of hoarseness or loss of voice as a basis for diagnosis becomes more apparent. I have three patients, all married men, with apparently healthy families, under my care. One had the primary sore seventeen years ago, one twenty-six years and one thirty years. Two of them had gummas and one had

deep ulceration when they came under observation. In none of them was the diagnosis made until I saw them and in none of them were there co-existing lesions to aid the practitioner in making a diagnosis. The aphonia and dysphonia present in these cases only pointed to disease of the larynx; the nature of the diseased process they in no way revealed.

Next in importance, probably, is that group of cases suffering from laryngeal neoplasms, both benign and malignant. It will be readily understood that as a rule the signs and symptoms of a growth in the larynx depend on the nature, on the exact situation and on the size of the neoplasm. Thus a growth on the vocal cords causes aphonia or hoarseness; the growth on the epiglottis produces dysphonia; and a large tumor, wherever situated, is likely to give rise to dyspnea. Sir Morell Mackenzie says, from the varying and peculiar character of the voice, the croupy cough and the paroxysmal dyspnea, the presence of a growth may be occasionally inferred by the experienced laryngologist, but those who have not met with many laryngeal polypi would be rash to form a diagnosis from such symptoms.

At the time of writing this, December 31, 1878, Mackenzie had operated upon 223 cases of non-malignant growths of the larynx and was well qualified to estimate the value of vocal impairment as a diagnostic guide. He admits, however, that "alteration in the voice, though not always present, is the most constant symptom of a growth in the larynx." In his first 100 cases the voice was impaired 92 times, aphonia being present 55 times and dysphonia 37 times. Impairment of the voice was the only symptom in no less than 52 per cent. of his cases. It will be seen, therefore, that while loss, or partial loss, of the voice, though more often present than any other symptom, is a very deceptive sign of a laryngeal neoplasm, especially when unassociated with dysphagia, or dyspnea.

I here exhibit a drawing of a multiple papilloma of the larynx, where the hoarseness present was not greater than

is often observed in a case of moderately severe chronic laryngitis. One would suppose from the combined size of these growths that more or less complete aphonia would have been present. These growths were pediculated and upon this circumstance was the comparatively good voice dependent. The air in the effort of phonation forced the growths away from the glottis and cords, permitting the latter to come together and vibrate almost normally. This case I operated upon by means of Mackenzie's laryngeal forceps at my clinic at the Baltimore Medical College and I had the opportunity to examine the man's larynx one year after, when there had been no recurrence of the growth.

About two months since I saw a case of what I took to be a fibroma of the larynx in the person of one of Baltimore's most progressive business men, the growth being sub-glottic, about the size of a Delaware grape, and located at the anterior commissure of the cords. This, while only about one-third or one-fourth the size of those in the plate before you, gave rise to nearly as much hoarseness. Here the air in phonation forced the growth against and partially between the cords. I will say in passing that this case had been treated by a homeopath for seven months for chronic laryngitis and then sent abroad to travel for some months with the hope that this would completely restore his voice. The patient told me before sitting down to the laryngoscope that he was suffering from chronic laryngitis, and relying alone on the hoarseness, I told him that I felt sure he was. I was not a little surprised to find the larynx free from inflammation, but the site of a growth. In malignant growths of the larynx the vocal impairment grows progressively worse; it does not come to a standstill, as is not infrequently the case in benign growths, but this symptom would not enable us to differentiate it with any certainty from the grave diseases of the larynx.

The last group of laryngeal diseases which merits our attention is the neuroses of the larynx. Of these, the nervomuscular neuroses only will have any

bearing upon this paper, the sensory neuroses being excluded. Neuroses of motion are divided into two natural classes, viz.: (1) those with loss of power, or paralysis; (2) those with perverted power, or spasm. It will be sufficient for the purposes of this paper to consider only the more prominent of them. Among those of the first class, hysterical paralyses form an interesting group in which aphonia or dysphonia are constant symptoms. I have notes of six cases treated in 1895, of which five had aphonia and one dysphonia. The one which was of longest duration was nine months, and that of the shortest duration was three weeks. Every one of these was cured by various means so promptly that no doubt about the diagnosis could be entertained.

The suddenness of the aphonia, taken together with other hysterical symptoms, make the diagnosis in some cases very certain, but not a few cases in my experience are associated with catarrhal affections of the larynx or supervene during the progress of the latter and thus seriously complicate the diagnosis, not only so far as the general practitioner is concerned, but even the specialist at times as well. Taken all in all, however, the aphonia in this class of cases has as much diagnostic value, interpreted in the light of other symptoms, as it has in most laryngeal diseases. In the majority of the cases, nevertheless, which have come under my observation, no other reliable hysterical symptoms were present. Its diagnostic value is therefore limited to a comparatively small number of cases. Of other motor neuroses, such as adductor and abductor paralyses, the aphonia or dysphonia in the former is not characteristic, while in the latter, one of the gravest of the laryngeal neuroses, the aphonia, or even dysphonia, may be altogether absent. In paralysis of the arytenoideus or tensor paralysis, the experienced laryngologist rightly interprets the aphonia or dysphonia accompanying them, but they furnish little information to the general practitioner beyond the fact that there is laryngeal disease present.

Before closing this paper I wish to re-

fer to a most interesting case, without reporting it in full, which came under my care about October 1, 1895, which falls under the second group of neuroses, those in which the spasm of the adductors is the pathological element present in the larynx. This group must be sharply differentiated from spasm of the glottis. The spasm takes place on inspiration in the latter, while in the former it occurs on expiration. There are three conditions under which these spasms on expiration may take place; (1) where spasm occurs on expiration without phonative effort, the air breaking forth with a sudden explosion; (2) where it only occurs on phonative effort; and (3) where the spasm is only relaxed when the patient falls unconscious to the floor, as in laryngeal vertigo. My case belonged to the second of these divisions and spasm of the adductors was only present on efforts at phonation.

The interesting feature of it is that it simulates somewhat one or two laryngeal neuroses which occur much more frequently and are accompanied by what is known as phonative waste, *i. e.*, a waste of air during phonation. The physician who referred this case to me paid me a visit before the patient did and on questioning him I became convinced that it was paralysis of the interarytenoid muscle, as it was accompanied by laryngitis. I saw in a moment, after seeing the patient, that he had mistaken the panting for breath after the spasm had passed off for what I had described as phonative waste. The character of the dysphonia in this class of cases is significant, but only so in a useful degree to the laryngologist of considerable experience.

If I am right in the views I have expressed in this paper, I think it clearly follows, to use a somewhat paradoxical expression, the definite diagnostic value of aphonia and dysphonia as symptoms of laryngeal disease is very indefinite.

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URETHRAL DILATATION.—The benefit from local applications through the cystoscope to wall off the female bladder is said to be due in reality to the dilatation of the urethra.

## OPERATIONS FOR NON-MALIGNANT STRICTURES OF THE RECTUM.

READ BEFORE THE CHICAGO GYNECOLOGICAL SOCIETY, DECEMBER 20, 1895.

By Joseph B. Bacon, M. D.,  
Chicago.

THE history of surgery shows that the treatment of non-malignant strictures of the rectum has been far from satisfactory and that the malady has baffled the skill of surgeons. While the patients were temporarily relieved, the inevitable return of the stricture and final obstruction of the bowel, or perforation of the ulcerated gut above the stricture, or the gradual amyloidal visceral changes due to the pus infection from the ulcerated surface, gave results so sad that it was of small consequence to the patient whether the stricture was malignant or non-malignant.

The common practice among surgeons has been to gradually dilate or divulse, or to perform internal or complete proctotomy. Gradual dilatation by means of hard or soft bougies is an excellent palliative remedy for strictures situated in the lower third of the rectum, but in strictures above this point nothing can be more dangerous. It is the rule in stricture of the rectum for the mucous membrane, and often the muscular coats of the gut, to be the seat of ulceration that may vary in degree even to all but perforation into the perirectal space. Passing a bougie is very liable in such cases to perforate the thinned gut wall and so to cause death. At best, the treatment by bougies is rarely curative, and usually necessitates an indefinite prolongation of the treatment and its accompanying risks. The accidents and deaths accompanying divulsion have been so common as to cause, practically, all surgeons to abandon this operation.

Linear internal or complete proctotomy has, as a rule, been ultimately disappointing, not only on account of the return of the stricture, but also by reason of the frequent occurrence of fecal incontinence after the division of the

sphincter ani muscles. The incision, which leaves an open wound, gradually unites by granulation, and, with few exceptions, adds new fibrous tissue to the old stricture and in from one to two years the patient's condition is as bad as, or worse, than before the operation.

Electrolysis has of recent years had its enthusiastic admirers, but the surgeons who have tried it are gradually becoming discouraged with it and at present consider the method but little if any better than gradual dilatation by means of bougies. When the period of aseptic surgery arrived, surgeons felt sure that by excising the stricture, even in those cases where the peritoneal cavity would necessarily be opened, and by reuniting the gut by end-to-end approximation, they would be able to successfully treat these strictures. The fatalities following the operation, however, made their statistics most discouraging. The tension upon the sutures was so great that frequently they gave way, and infection of the peritoneal cavity resulted. In many cases the ulceration above the stricture was so extensive that suturing was almost impossible.

With the advent of the large Murphy button the results of end-to-end approximations were much better and the danger from stitch fistulas and peritoneal infection was reduced to the minimum. Thus the immediate results of the excision operation were a pronounced success. The remote or secondary results, however, proved a failure with every form of end-to-end approximation. The circular cicatrix left either by the button or the sutures acted as a center of irritation to the enormous amount of fibrous tissue in the rectal walls, and, together with the fascia in the pelvis, added new cicatricial tissue, and the

gradual contraction eventually formed another stricture. It was exceptional for any case to terminate otherwise. The rectum is imbedded in fibrous tissue, and any wound of this organ must leave a more dense cicatrix than at other parts of the intestinal tract. It is a well known pathological fact that the fibrous tissue adjacent to a cicatrix becomes hypertrophied and finally contracts, and thus adds to the original scar. If this be circular, as in the rectum, a mild stricture is formed, which, by irritation from peristalsis and the passage of fecal matter, becomes more and more formidable by the changes in the anastomotic fascias and connective tissue.

With the discouraging results shown by the literature upon the subject and with quite a number of unsuccessfully treated cases of rectal stricture in my practice, I determined to try to devise a method for permanent cure. I therefore began a series of experiments upon dogs and have devised a method that I think will permanently relieve all strictures situated above the levator ani muscles, and stricture in the female which extends down almost to the internal sphincter muscle, as the vagina can be separated from the rectum. The operation is practically as free from risk as any ordinary laparotomy, as the following case will show:

Dr. Effie Lobdell of the Harvey Hospital—who sent the case to me, had the patient under her care for the past year and had given her a long and thorough treatment with potassium iodide, and had frequently dilated the stricture with bougies—furnishes the following history:

"Mrs.—, English, aged fifty-three, twice married, had twelve children by first husband; all well developed and healthy except the last, which died soon after birth. Has also had one still-born child and two miscarriages. Patient has usually had good health. Mother died of old age, father of supposed cancer of rectum at fifty-five. Brothers and sisters all living and in good health.

"Patient has had gonorrhea twice,

and twenty-eight years ago contracted syphilis. A servant 'cured' her of the former. The husband administered mercurials to her for the latter, and she was salivated, losing all her teeth and hair. Had a general eczema over the trunk of the body. A physician finally effected a cure. During this year she was delivered of her last child, which showed characteristic marks of syphilis and died in a few days. Since that time her health has been excellent until three years ago. She has suffered from chronic constipation and hemorrhoids, both internal and external, for which she underwent operation at a hospital in 1892, during which the external sphincter was accidentally severed. Last summer she had an attack of nervous prostration; was in the hospital five weeks; the trouble in the rectum also began at this time, for which she received no treatment.

"She consulted me for vesical and uterine difficulty, which yielded to treatment, and I incidentally discovered the rectal trouble while treating her. She had had incontinence of feces for about five years.

"Upon vaginal examination, I found the uterus anteverted, cystocele, laceration of perineum and cervix, prolapsed vaginal walls, and incomplete procidentia. The urethra was inflamed and sensitive. She gave a history of cystitis, and complained of frequent and painful micturition.

"Following up the uterus posteriorly with the index finger, I outlined a tumor several inches long and probably two to three inches broad lying along the rectal wall.

"I prescribed for the patient potassium iodide in increasing drop doses, and the accumulation of tissue perceptibly diminished."

Upon examination, I found a tubular stricture extending from a point just above where the levator ani muscle encircles the rectum up beyond the reach of my finger, and so contracted that my index finger was barely able to enter it. The rectum was filled with pus, blood, and a great deal of mucus, denoting that there was a large ulcerated surface above

the stricture. The external sphincter was greatly relaxed, and the patient was suffering from incontinence of feces as a result. The muscle had probably been overstretched or divided during the previous operation. I ordered the patient to bed and put her on liquid diet for a few days preparatory to operation. Instructions were given to thoroughly empty the bowels by means of high enemata of a solution of two drachms of ox gall to one pint of water and to avoid cathartics, as violent peristalsis might rupture the ulcerated gut.

June 22, 1895, assisted by Drs. Ferguson, Lobdell, Waite and Stremmel, I made an incision into the abdomen in the median line extending from the umbilicus to the pubes. Then, by placing the patient in the Trendelenburg position and crowding the small intestines back with large flat sponges, I could see and feel the stricture and judge of its length, which was between three and four inches. The sigmoid was secured and bent down over the stricture to a point deep into Douglas' pouch below the lower limit of the stricture and the length required noted. The sigmoid was now drawn up to the abdominal incision, and at the point noted one-half of the smallest-sized Murphy button was securely sutured in place, and this portion of the sigmoid wrapped in a sponge and left in care of an assistant. Another assistant now inserted the other half of the button by means of a buttonholder through the anus, up the rectum to the lower limit of the stricture, and turned the staff of the button toward the anterior rectal wall. By firmly pressing it against the wall I could feel and see the instrument from above, and by gently nicking the gut over this point the small staff of the button protruded through the gut wall and was sutured in place and firmly held by the assistant with the buttonholder. I next scarified the peritoneum over the stricture and sigmoid, the surfaces to come in apposition from one-half of the button to the other. Now, taking the half of the button in the sigmoid, I again bent the sigmoid down over the stricture so as to have the scarified surfaces come in appo-

sition, and united it with the half of the button below the stricture, and thus formed a lateral anastomosis of the sigmoid and the rectum below the stricture. My intention was to suture the approximated surfaces of the rectum and sigmoid together along the scarified surfaces, so as to avoid the possibility of a loop of small intestine getting caught between them and being clamped off when the operation was completed. But on placing the lower half of the button, notwithstanding the great care taken to make only a small opening just for the staff, I noticed that pus and blood from the rectum entered the abdomen at this point and thus necessitated a drainage-tube with gauze from the bottom of Douglas' pouch. This gauze or Mikulicz drain was now placed and packed so as to firmly hold the sigmoid and stricture in apposition until the scarified surfaces could unite and form a firm septum from the button to the upper limit of the stricture.

The abdomen was now closed with silkworm-gut sutures up to the drainage-tube and the wound, dressed with iodoform gauze, was covered with sublimated cotton and a firm roller bandage. Recovery from the operation was uninterrupted.

The drainage-tube was removed on the second day and the balance of the gauze drain on the seventh day. There were liquid bowel movements daily. The button came away on the ninth day, when an ox-gall enema was given and a good liquid stool secured. These enemata were continued daily and a good nourishing liquid diet continued until the patient gained strength. A clamp was placed without anesthesia on the forty-seventh day, which came away on the fiftieth day. The patient was now given a generous diet of good variety and rapidly gained in strength, and after the sixtieth day was up and around the ward.

I find upon examination now, although only five months have elapsed since the operation, that the greater part of the fibrous tissue has been absorbed, and that there is a large free opening between the rectum and the sigmoid quite suffi-

cient for the passage of solid formed feces. The ulceration above the stricture has greatly improved and will probably soon disappear.

I used the small Murphy button, because all that was required of it was to form a fistulous tract between the sigmoid and the rectum below the stricture so the clamp could be applied to the septum. In this case I did not apply the clamp so as to cut away the whole septum, because in so long a tubular stricture it is not necessary to clamp away so much tissue. If from any cause it should be thought best to clamp away more of the septum it can be easily done, as there is comparatively no pain in the use of the clamp, which can be applied without an anesthetic. I had this clamp constructed so that one blade could be inserted at a time and then locked. The slots in the handles were left so as to fasten a rubber ring over the handles after the clamp is first placed on the septum and thus gradually clamp away the tissues the first twenty-four hours; then, as the handles are approximated by the elastic pressure of the ring, they can be finally clasped together and the septum will be severed in a few days. To clasp the instrument the first day might produce too rapid sloughing and thus set up a gangrenous spot that would not be limited to the septum.

The object in folding the sigmoid upon the stricture is to have a normal piece of gut united to the ends of the stricture band that has been severed by the clamp, and thus to prevent their reunion and reformation of the stricture.

In this operation there cannot be a return of the stricture, and the large opening left for the passage of feces relieves the irritation of the old stricture tissue, which gradually becomes absorbed. The ulceration of the rectum above the stricture disappears. The sphincter ani muscles are left intact and continence is assured. It is impossible to place the lower half of the button in the rectum without infection of the peritoneum and therefore a drainage-tube, with packing of iodoform gauze, should always be used to insure drainage and wall off the general peritoneal cavity

and thus limit the infection. A stricture formed in the lower end of the rectum extends so near the internal sphincter it would be rarely possible to use the method as described in the above case.

I have now operated upon twelve cases, the first one fourteen months ago. The patient has gained about thirty pounds in weight and there is a large free opening where a very tight stricture was formerly located, and I have every reason to think her permanently cured. Even this case is too recent to be assured that the recovery will be permanent. The other eleven are doing well and in no case has there been any serious complication or sepsis.

The operation for stricture in the lower end of the rectum is simple and quickly performed. It consists in making a mucous fistula around the stricture from a point below its border posteriorly in the median line between the stricture and the coccyx, terminating in the rectum as an inner opening above the upper border of the stricture. A heavy silk ligature is passed by means of a blunt-pointed needle similar to an aneurism needle and left in place for three months, when it is removed and a probe-pointed grooved director passed through the fistulous tract and the stricture severed with a Pacquelin cautery down to the director. The object is to have a mucous tract at the bottom of the wound that will prevent the ends of the severed stricture from becoming reunited, as is the case in the ordinary linear proctotomy. Theoretically this is possible, but the cases are too recent to prove that the stricture will not recur; still, they show better results than occur after ordinary proctotomy, and this operation does not interfere with the sphincter muscles, which is very important.

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PSEUDO-PERTUSSIS.—Dr. Pradel relates in the *British Medical Journal* a case of pseudo-pertussis in a boy who had a small pebble in the trachea. He had attacks of laryngismus stridulous for months until it was expelled in severe spasm. A careful laryngoscopic examination at the time might have afforded prompt relief.

## Society Reports.

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### CLINICAL SOCIETY OF MARYLAND.

MEETING HELD JANUARY 17, 1896.

THE 317th regular meeting of the Clinical Society of Maryland was called to order by the President, Dr. J. M. Hundley.

*Dr. S. K. Merrick* read a paper on THE DEFINITE DIAGNOSTIC VALUE OF APHONIA AND DYSOPHONIA AS SYMPTOMS OF LARYNGEAL DISEASE, from the standpoint of the general practitioner. (See page 361.)

*Dr. John Winslow*: The sum and gist of this paper is presented in the last few words, that "aphonia and dysphonias as definite diagnostic symptoms are of very doubtful value." We may have the most marked cases of aphonia or dysphonias where there is little laryngeal affection. A laryngoscopic examination should be made in all cases where we have any reason to suppose that there is laryngeal trouble. It is impossible without such an examination to say that there are, or are not, diseases within the larynx. Patients often come to the specialist with the history of having been treated for months for chronic laryngitis when, upon examination, he discovers growths in the larynx. In regard to tuberculosis I would go even further than Dr. Merrick and say that in all cases of this disease the larynx should be examined, for such an examination is in the interest of the patient. We can detect the general tuberculosis in the larynx before we can elsewhere and it is in this early stage of the disease that the most good can be done. I quite agree with Dr. Merrick that a case of so-called acute laryngitis which has run on for two weeks or more should be carefully examined. This is not generally done and they are usually treated by sprays until we have a condition extremely difficult to cure. I do not believe in the spray treatment for sub-acute or chronic laryngitis.

*Dr. H. Clinton McSherry*: From the standpoint of the general practitioner I am sorry to say that the laryngoscope

does not play an important part in his practice. In cases we ordinarily meet with there is some trouble in the chest that may account for this aphonia or dysphonias; it may be an aneurism, or as I called attention to some years ago, some thickening or enlargement of the bronchial glands that press upon the nerves and produce a cough, followed later by dysphonias and aphonia. There are many other conditions of the lungs that will produce this trouble and we know that chorea of the larynx is of common occurrence. There is also the condition of aphonia or dysphonias spastica. In the first, the voice is entirely lost; in the latter there is ability to speak, but whenever it is attempted spasm of the larynx is brought on.

*Dr. W. F. Lockwood* read a paper on TUBERCULAR MENINGITIS, Report of Eleven Cases."

The Society then adjourned.

H. O. REIK, M. D.,  
Secretary.

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### Correspondence.

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#### HOMEOPATHISTS IN OFFICE.

BALTIMORE, Feb. 27, 1896.

Editor MARYLAND MEDICAL JOURNAL:

*Dear Sir* :—I did not think it possible, in this day of grace, to live to see acknowledged sectarians appointed upon our Health Board, or as physicians in our public penal institutions; and I wish to enter a protest against the recent appointments of such men, considering such action as an insult to regular medicine and a decided retrograde movement in the stride of nineteenth century science. So long as irregular practice is allowed in the State, and colleges exist for the promotion of knowledge along irregular and sectarian lines, I presume it is necessary for irregular medicine to be represented upon our State boards of examiners, so that the fitness of the graduated irregulars may be passed upon by some one who understands their marvelous methods, before they are allowed to practice upon the ready credulity of the public.

Personally, I do not believe there is a sincere homeopath in our city ; that is, one who adheres strictly to the teachings of the founder of the sect, but, be that as it may, I do not think that any sectarian, be he homeopath, eclectic, hydro-path, or Thompsonian, should be appointed or elected to fill an office within the province of medical science in city or State, and in saying this I believe I voice the sentiment of every regular physician within the borders of the State of Maryland, or indeed the United States. It has been fully demonstrated time and time again, and indeed the reasons are so plain that they should not require to be demonstrated, that a regular physician cannot consult with a homeopath, and while the same reason may not exist in the Health Office, for perfect accord in matters of medical faith, I do not believe that a regular and a sectarian can work harmoniously upon the same board.

Dr. Conlyn is a personal friend of mine, and while I am sorry to feel it my duty to write this letter, I would do the same thing were my own brother in his place.

The number of patients in the jail requiring or expecting homeopathic treatment is necessarily small, and if we must humor such vagaries on the part of our criminals, let the council pass an ordinance permitting the attendance of a homeopath when the Jail Board, or, better still, the Jail Physician, who shall be a regular physician, deems the humoring of such vagaries advisable. Our worthy Mayor has made so few mistakes that if this were in the realms of anything else save that of medical progress I should still regret the mistakes, for the sake of a broken clean record, but I would keep silent.

Hoping most earnestly that the present appointees may be relieved and regular physicians be appointed, or if they be allowed to serve their terms, that for all future time none but regular physicians be appointed, believe me,

Yours truly,

B. MERRILL HOPKINSON, M. D.

5 West Saratoga Street.

BALTIMORE, Feb. 27, 1896.

Editor MARYLAND MEDICAL JOURNAL :

Dear Sir:—I have corresponded with Dr. Hill, President of the Medical and Chirurgical Faculty, and he heartily endorses my opinion that the appointment of a homeopath in association with Dr. McShane in the Health Department should be prevented. It is a great blunder on the part of Mr. Hooper, a professional and scientific incompatibility. How can two men with diametrically opposed views work together in the municipal sanitary departments successfully?

No city in Europe has ever appointed a homeopath to a place in its hygienic administration. In this country the effort (thus far it is only an effort) is an isolated one. Homeopathy is a mingled mass of perverse ingenuity, of artful misrepresentation, practicing imbecile credulity. It is the most gigantic humbug of the age and would be as dead in this country as in Germany if too much recognition were not paid to it.

Please inform me who is the corresponding secretary of the Clinical Society and his address, as I propose stirring up the medical societies on this insane political appointment. It will be a card for your journal to interview the representative medical men on this subject and contest the expediency of it.

Yours truly,  
JOHN C. HEMMETER, M. D.  
1734 Linden Ave.

HEREDITARY PREDISPOSITION TO KELOID IN A COLORED FAMILY.—Dr. Alex. L. Hodgdon reports the following case : Mary T. is affected with keloid and has heard that her father was a sufferer from it also, and some of her half-sister's children, by her father. Mary T.'s daughters, Ella and Maggie, have the same disease. Ella has it on her ear where it was pierced and Maggie at the site of a burn on the neck. Mary T.'s son is affected with it, the location being an old burn on the neck. Mary T.'s daughters, Lena and Jessie, are free from the disorder.

## Medical Progress.

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### RECENT PROGRESS IN DERMATOLOGY.

By T. C. Gilchrist,

M. R. C. S. (ENG.), L. S. A. (LOND., ENG.).

Assistant in Dermatology, Johns Hopkins Hospital,  
Lecturer on Dermatology at the Baltimore  
Medical College and at the Woman's  
Medical College of Baltimore.

### ADVANTAGES DERIVED FROM THE STUDY OF DERMATOLOGY.

The well known dermatologist, Stephen Mackenzie of the London Hospital, London, England, gave an excellent inaugural address before the Reading Pathological Society on the above subject. He says that diseases of the skin afford one of the best training grounds for educating the observant faculties, and there is no branch of medicine which offers the same opportunities of training the mind to observe the phenomena of diseases and of inculcating the principles of treatment. Nowhere else except on visible mucous membranes can be observed the whole of the classical symptoms of inflammation. In the fauna and flora of the skin excellent studies are afforded to the zoologist and botanist. Not only can almost every variety of neoplasm be studied, but the physiological factors are of great interest and importance. He emphasizes the influence of age, sex, climate, season, occupation, personal hygiene, as etiological factors in skin diseases.

Attention is drawn to a peculiar affection, which is a follicular inflammation occurring on the hands, forearms, face and neck of those engaged in the manufacture of certain products from gas refuse. A case is also mentioned where a man had a persistent eczema as the result of working with quinine in its manufacture, and another similar case is cited where the eruption was due to the manufacturing of tobacco. Mackenzie believes that the greater frequency of premature baldness in the male is due to the rigid head coverings which are worn out-of-doors and which constrict the blood vessels supplying the hair follicles, besides confining the air and raising the temperature of the top of the head.

With reference to diathesis and disease he remarks that it consists in invulnerability and special and individual tissue proclivity. It is from a study of herpes zoster that most of the present knowledge of the influence of the nervous system in the causation of diseases of the skin has been derived.

In connection with the effect of diet on diseases of the skin Mackenzie quotes Walter Smith's valuable summary, viz.: 1. Very few diseases are directly traceable to dietetic causes, but improper diet may aggravate existing eruptions. Idiosyncrasy must be largely allowed for. 2. The diseases that may so arise are of a transitory character and mostly belong to the class of erythema. 3. Diet has very little influence in promoting the cure of cutaneous eruptions. The results are far behind popular expectation, even in such cases as acne rosacea, where we are led to hope for much. 4. Avoidance of alcohol, regulation of the bowels and the cure of anemia are of infinitely greater importance than special dieting in the management of diseases of the skin.

### FOUR RECENT CASES OF EXTRA-GENITAL SYPHILIS IN PRIVATE PRACTICE.

The well known dermatologist and syphiligrapher, Dr. L. Duncan Bulkley, adds (*Journal of the American Medical Association*, January 11, 1896) four more cases to the long list of extra-genital chancre of syphilis which he has already recorded. The first case was that of a chancre of the cheek in a woman, the second was that of a chancre of the finger in a physician; in the third case the chancre was situated in the right nostril of a woman, and the fourth example was a chancre of the left tonsil in a man. He says "that few realize with what relatively great frequency the point of entry of the syphilitic poison is in the region of the mouth and throat." Including the four cases just mentioned, Bulkley has seen one hundred and twenty cases of extra-genital chancre in his private practice. Of these, fifty-one occurred on the lips, sixteen on the tonsil and sixteen on the finger. The male cases were slightly in the preponderance,

a fact which is in opposition to the common belief. He concludes by saying that we should be extremely careful in charging an individual with wrongdoing, for the disease is much more frequently acquired innocently than is commonly thought.

#### CONDYLOMATA.

Dr. W. S. Gottheil (*American Medico-Surgical Bulletin*, January 11, 1896), in an article on condylomata gives some interesting data with reference to the symptomatology, etiology and treatment of these excrescences. Condylomata are divided into acuminata and lata, the former being idiopathic non-malignant papillomatous tumors of the skin, whereas the latter are papules indicative of secondary syphilis. The condylomata acuminata are connective tissue new growth and on the surface present a papillary and ridged appearance, the sulci marking the division between the coalesced yet distinct tumor. These condylomata soon become infected with pus cocci and then they present a foul appearance. They easily bleed. Although gonorrhea has been proved to be the cause of the majority, yet in some no assignable cause can be found. The broad-based excrescences and the presence of other signs of lues distinguishes the condylomata lata from the condylomata acuminata.

From epithelioma in many cases the diagnosis is very difficult and often microscopical examination is necessary. When removal cannot be effected, then salicylic acid either in powder or solution is used and Thimm has used the 40 per cent. formalin as an external application with good results and very little discomfort to the patient. The condylomata lata are common in syphilis and are really papules altered in character by their situation. The treatment is that of lues and Gottheil always uses the subcutaneous injections when the patient permits it as being the surest, quickest and most effective method of treatment.

#### MADURA FOOT DISEASE IN AMERICA.

Adami and Kirkpatrick (*Montreal Medical Journal*, January, 1896) describe in detail the first indubitable case of my-

cetoma recorded as occurring upon the American continent in a patient who had never traveled outside that continent. The affected limb, which was amputated, was exhibited before the Medico-Chirurgical Society of Montreal and another specimen, also an amputated limb from a case occurring in the service of Dr. Hyde of Chicago, was also presented as a comparison. The history of the two cases was similar, the ray fungus being the specific organism in the disease and this fungus is distinct from actinomyces. The cases recorded were of 13 and 10 years' duration respectively and both began on the foot like buttons of flesh, which formed the mouths of sinuses passing in all directions internally.

#### ELECTROLYSIS IN DERMATOLOGY.

Dr. Charles W. Allen of New York (*New York Medical Record*, January 25, 1896) discusses the question : 1. What can we promise an applicant for relief from a disfiguring growth of hair? 2. Does electrolysis tend to stimulate the growth of neighboring hairs? In answer to these he advises the removal of hairs, abnormal growths and blemishes from the face whenever they are a source of worry and annoyance. He is opposed to the removal of a fine silky and not at all disfiguring growth of hair upon the lip, or the removal of single moles so situated that they are regarded as beauty spots.

He mentions that a certain number of hairs always return, and he believes that near-by hairs are excited to growth by the application of the current; so he advises against removal of hairs near the corner of the mouth. Any good galvanic battery will do for the operation. Instead of the usual procedure, Allen recommends that the hair be grasped with forceps and slight traction be made while inserting the needle. Only the physician should practice electrolysis for hair destruction and any painstaking physician can acquire the requisite skill.

The various forms of nevi which can be destroyed by electrolyzation are the nevus araneus, telangiectasis, nevi of limited extent and also superficial port-wine marks. He recommends a flat-

bladed needle for the removal of nevus papillomatous; lipomatodes and warty growths. Allen records a case of vascular nevus of the vulva in a baby seven weeks old, cured by electrolysis. He also has used electrolysis in elephantiasis, lupus, keloid, acne rosacea, milium, and xanthelasma of the eyelids; also for dilated sebaceous follicles and crypts.

With reference to freckles, where a few dark ones of good size are scattered over the face he removes them either by pricking lightly over their surface with a weak current of about half a milliamperé, undermining the epidermis with a fine needle until the surface is blanched.

\* \* \*

**LABOR IN KYPHOTIC PELVES.**—Klien (*Boston Medical and Surgical Journal*) comes to the following conclusions regarding labor in kyphotic pelvis from a study of his own and reported cases. He presents a table of 95 cases. Kyphotic pelvis are found in labor about once in 6,016 cases. They are generally developed in childhood on account of spinal caries. In eight per cent. the spinal column projects over the pelvis. Both inlet and outlet of the pelvis are narrowed from side to side and in the antero-posterior diameter. The inclination of the pelvis is diminished, while the true conjugate is almost always lengthened. The nates are flattened. Thirty per cent. of all kyphotic pelvis are also universally contracted. Three-fourths of the cases terminated by spontaneous labor, one-fourth prematurely. In a third of all head presentations the position was posterior, and face presentations were more common than in normal pelvis.

From 58 to 60 per cent. of the cases studied required operative interference. The mortality of the mothers in the cases most favorable for the mechanism of labor was 6.2 per cent., in unfavorable cases 17 per cent. The mortality of the children was about 40 per cent.

As regards treatment Klien advises the induction of labor in cases where the distance between the tuberosities of the ischia measures from eight and a quarter to six and a half centimeters. If the patient is not seen until the end

of pregnancy, symphysiotomy should be done, if the distance between the tuberosities of the ischia measures five and three-quarters centimeters. If a greater measurement exists, forceps can be tried. Cesarean section is only absolutely indicated when the distance between the tuberosities is less than five and a half centimeters, and relatively indicated when the distance is from five and a half to seven centimeters, if by it a living child can be obtained and symphysiotomy is undesirable.

\* \* \*

**LOGIC AND LIGHTS.**—Every now and then we come across paragraphs in newspapers headed, "Reading in Bed." Then follows a horrifying account about some one being found dead, with the bedclothes smouldering and the room full of smoke, and the paragraph writer then proceeds to dilate upon the danger of reading in bed. His logic is hopelessly at fault. Set out syllogistically it is as follows: "Some artificial lights will set fire to a bed. Those who read in bed, says the *Lancet*, use artificial lights. Those who read in bed will set the bed on fire." This argument, involving what is known as the undistributed middle, violates the fourth canon of the syllogism. The last case of this kind which has come to hand is that of a woman who read in bed holding a candle in her hand. Presumably she dropped asleep and the bed caught fire, with the result that she was suffocated. This was only to be expected; but if people would only make it a rule to have some sort of light at some distance away from the bed by means of which they can read or work while in bed we should hear no more of these accidents. A candle or lamp on a table, given that the candlestick and table or lamp and table are heavy enough not to be upset easily, is safe. A gas bracket on the wall, or, better than all, an electric light, is again safe. Little portable accumulators can easily be obtained and give quite enough light to read by. The lamp is detachable and absolutely safe. Reading in bed is with certain obvious precautions no more dangerous than reading anywhere else.

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BALTIMORE, MARCH 7, 1896.

An interesting review of this rare disease is presented by Dr. Haushalter in the *Archives Cliniques de Bordeaux* with the report of a recent case occurring in his own

practice in the summer of 1895. The disease has been but recently described in the annals of medical science. Up to the time of the report only ten recorded cases could be found occurring in the newly-born, Dr. Haushalter's being the eleventh. This infant presented no family history of moment except of rheumatism in the father. This parent denied having had gonorrhea, but the mother had had leucorhea to the fourth month of pregnancy. The child showed signs of ophthalmia, with discharge from the eyes at the third day, did not improve under the mid-wife's remedies and on its eighteenth day of life was brought to the clinic. Double purulent conjunctivitis was found, with complete infiltration of both corneas. The sight was

permanently lost in both eyes, although the conjunctivitis quickly improved and healed (by the 48th day of life), under antiseptic washes.

When the baby was twenty-five days old the mother noticed a swelling of the left wrist, and two days later of the right knee. There were friction sensations in the sheaths of the flexor tendons on the left forearm, which was swollen and edematous in its lower third and painful on motion. In the right knee the swelling was due to distention of the synovial cavity, fluctuation being plainly perceived. This knee was kept by the little patient semiflexed and seemed painful. Exploratory puncture of this knee joint with sterilized syringe revealed a slightly opaque fluid containing many polynuclear leucocytes. This puncture was made on the 30th day of life and the 5th of the swelling. Repeated and exhaustive examinations of the fluid withdrawn revealed no gonococci, although they were clearly shown in pus discharged from the patient's eyes. Culture, however, made with the joint fluid in bouillon behaved like gonococcus cultures and gave micrococci absolutely identical in appearance with those seen in a pure culture of gonococcus made from the pus of a fresh gonorrhea. The fact therefore that gonococci were not found in the joint fluid does not show that the rheumatism was not gonorrhreal, especially in view of the fact that Jacquet on one occasion searched for a long time for gonococci in the joint pus of a gonorrhreal rheumatism without finding any, until at last he hit upon one solitary cell just crowded with them.

The signs of knee effusion in this patient and the swelling of the wrist lasted only about ten days in all. At the end of this period the pain disappeared and the movements became easy. When the child left the hospital and was lost sight of, twenty-four days after the joint trouble appeared, there was left only a little thickening of the articular surface of the knee. This was the only recorded case in the newly-born where enlargement of the knee-epiphyses persisted. In all these others the duration of the arthritis was very short and recovery was complete in a period varying between fifteen days and a month, without the persistence of any signs whatever of the disease.

The patient now under consideration had no fever during the attack as far as observed.

It had a looseness of the bowels which might be ascribed to bottle-feeding. It received no local applications whatever to the affected limbs, yet the duration of the joint trouble was not longer and the result not less favorable than in those reported cases where anodyne applications, such as warm fomentations, or painful applications, such as counter-irritants, or fixation by apparatus were used. Although in this case the corneas were infiltrated and rendered permanently useless, no causal relation between the arthropathy and the depth of the ocular lesion can be inferred, since in most of the other arthritic cases reported, the conjunctivitis healed quickly without leaving any traces. On the contrary, the observers believed that the hereditary predisposition of the articulations received from a father subject to frequent attacks of acute articular rheumatism played an important part in the fixation of the gonococcus in the joints. In the newly born the gonorrhreal arthritis is apt to affect but few joints. Out of ten cases previously recorded, the knee alone was attacked in six cases. Location in the knee is much more frequent in infancy than in childhood or in adult life; which proves that the preference for this joint is not due to fatigue or injury received in walking. In conclusion, as far as may be judged from eleven cases, gonorrhreal rheumatism in the newly born affects almost always the knee, avoids the small joints, runs a short course, and heals quickly without leaving traces.

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**THE** appointment of two homeopathic physicians by the present administration to city positions has aroused indignation among the regular profession and there seems to be some justice in this disapproval. As stated recently, it was probably done by the Mayor in his endeavor to be impartial.

As stated last week, the principles on which the two schools of medicine are supposed to differ can hardly play any part in the duties of the assistant health commissioner, who has heretofore been little more than clerk or secretary and has given his principal attention to the abatement of such nuisances as affect the health, and it is probable that a homeopathist could have premises inspected and alleys freed from dead cats, rats, dogs and other

animals with as much dispatch as a regular physician.

It is a little hard on those in jail, to have in addition to the incarceration, the compulsion of being treated according to the principles of Hahnemann or not at all. As one of the correspondents intimates, there are few homeopaths and certainly there are none in Baltimore and probably none in New York and few who would dare to practice medicine according to the fixed rules which their self-imposed name demands. The Mayor made these appointments with all good faith and with a desire to be fair to all parties and he must not be blamed if he cannot understand what are called the different schools of medicine. A man cannot be expected to know everything. It might be of interest to compare the mortality and morbidity statistics in the jail of the next two years with the past two years. The so-called homeopathic treatment often benefits greatly because it does no harm.

Whatever calamity comes upon the jail can hardly affect those outside of its stone walls, but as for the health office, if a good health commissioner in the office holds the reins, the assistant can do little to make his belief harm his work.

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**THE** article in this issue by Dr. S. K. Merrick brings out the importance of the use of the laryngoscope to the general practitioner and in Diagnosis. Shows how necessary it is for the general practitioner,

that rapidly disappearing specialist, to have some acquaintance with special methods. The oculist is necessarily skillful in the use of the ophthalmoscope and should excel in refraction work, but the general practitioner should none the less know how to examine the fundus in suspected Bright's cases, or trace the cause of defective vision. The man who professes to do much chest work should not overlook the larynx. A continued hoarseness is always suspicious, just as a continued headache, and in the former case a careful examination of the laryngoscopic image should be made and it is just as well to examine the expectoration, as in laryngeal phthisis the sputum is usually heavily laden with tubercle bacilli and if anything can be done for such a case it should be done early, when there are some chances for recovery.

## Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending February 29, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		38
Phthisis Pulmonalis.....		34
Measles.....	51	1
Whooping Cough.....	6	1
Pseudo-membranous } Croup and Diphtheria. }	11	7
Mumps.....	5	
Scarlet fever.....	15	
Varioloid.....		
Varicella.....	1	
Typhoid fever.....	7	3

Mr. Frederick M. Shepard of East Orange, N. J., has given \$10,000 to the Orange Memorial Hospital, for the construction of a pavilion for consumptives.

Dr. James T. Jacobs of East New Market, Dorchester County, Maryland, died at his home last week. Dr. Jacobs was graduated in 1855 from the University of Maryland.

On the Board of Managers of the Manhattan State Hospital for the Insane recently appointed by Governor Morton are two women, Eleanor Kinnicutt and Alice Pine.

The people of Great Britain consume between six and seven million pills daily. Supposing these round masses to average three grains each, they would aggregate a ton in weight.

Bellevue Hospital Medical College and the Medical Department of the University of the City of New York will extend their medical course to four years. The change goes into effect at the beginning of the next session.

Health Commissioner McShane and Dr. Gustave Lehmann, the newly appointed chemist of the Health Department, had a conference with Mayor Hooper last week regarding the establishment of a municipal laboratory, which the city has never had, and Dr. McShane went to New York to examine the municipal laboratory there.

The death is announced of Dr. James Armitage of Baltimore. Dr. Armitage was graduated from the University of Maryland in 1831, and was a member of the American Medical Association and of the Medical and Chirurgical Faculty of Maryland. He was eighty-five years old.

In consideration of the efforts made by Mr. George S. Davis, the well known Detroit publisher and member of the firm of Parke, Davis & Co., in the past and present for the maintenance of the *Index Medicus*, the Société Francais d'Hygiène of Paris has elected Mr. Davis a Foreign Associate Member, thus emphasizing the recognition of his services to medical literature.

Every person, firm or corporation employing females in any manufacturing, mechanical or mercantile establishment in New Hampshire, will henceforth, by act of the Legislature, be obliged to provide suitable seats for the use of the females so employed, and shall permit the use of such seats by them when they are not necessarily engaged in the active duties for which they are employed. A fine of not less than \$10, nor more than \$30, is the penalty prescribed for each violation of this law.

The American Medical Publishers' Association will hold its third annual meeting in Atlanta, Ga., Monday, May 4, and considering the many recent applications for membership, a large attendance is assured. A number of new and important topics have been suggested for discussion and the programme will include papers from experienced publishers. Members and others desiring to contribute papers will be furnished valuable information upon communicating with the Secretary, Charles Wood Fassett, St. Joseph, Mo.

The Baltimore Medical Association held a banquet at the new Faculty Hall last week, in honor of its thirtieth anniversary. At the annual election of officers, Dr. Randolph Winslow was chosen President; Dr. Herbert Harlan and Dr. Joseph T. Smith, Vice-Presidents; Dr. W. E. Wiegand, Corresponding Secretary; Dr. Eugene Crutchfield, Reporting Secretary; Dr. C. Urban Smith, Treasurer; Drs. H. H. Biedler, E. G. Waters and John Neff, Executive Committee; Drs. Wilmer Brinton, S. T. Earle and John W. Chambers, Committee of Honor.

## WASHINGTON NOTES.

We are indebted to the Health Department for the following report: During the past week, 118 deaths (death rate 22.27) were reported, as against 112 (death rate 21.10) during the week previous and 134 (death rate 25.76) during the corresponding week of last year. The large mortality from pneumonia and diseases of the heart is the chief feature worthy of notice. Consumption was responsible for 13.5 per cent. of all deaths, a sufficient proportion, it would seem, to warrant the adoption of measures for its restriction. Diphtheria: two cases terminated fatally and seven were discharged from quarantine; thirteen new cases were reported; at the close of the week, 19 houses remained in quarantine. Scarlet fever: five cases were discharged from quarantine; 11 new cases were reported; at the close of the week 20 houses remained in quarantine. Typhoid fever resulted fatally in two cases and la grippe in four; no deaths occurred from either measles or whooping cough. Twenty-three deaths occurred in hospitals. Eight were certified by the coroner. Fifty-seven marriages were reported and ninety-four births.

On Tuesday, February 25, 1896, Dr. Smith Townshend died, after a lingering illness of long duration resulting from a second stroke of paralysis.

Drs. Jesse Shoup and A. W. Boswell have been appointed Physicians to the Poor.

It has been proposed to the Superintendent of Charities to establish about the streets and public places boxes for the reception of second-hand reading matter for the hospitals and charitable institutions.

The Medical Society of the District of Columbia held its regular weekly meeting on Wednesday, February 26, the President, Dr. Samuel C. Busey, in the chair. Dr. Wm. Forwood of the Soldiers' Home, D. C., presented specimens of very interesting cases of Rupture of the Gall Bladder. In one case of operation for primary cancer of liver, 419 gall stones were removed post-mortem. In another case of cirrhosis of liver, 705 gall stones were removed. He also presented other splendid specimens of gall stones. Dr. Louis Mackall read a paper on a case of A Foreign Body in the Pharynx. Drs. W. W. Johnston and C. W. Richardson discussed the paper and

stated that the same child had been under their care at that time and that they could discover no foreign substance in pharynx or larynx and believed it was in the stomach. The following committee were appointed to draw up proper resolutions on the death of Dr. Smith Townshend, a former Health Officer of this city, viz.: Drs. C. W. Franzoni, G. L. Magruder, G. N. Acker, J. D. Morgan and B. G. Pool. Dr. H. A. Robbins read an interesting paper on Syphilis of the Vital Organs, and Dr. Metzerott read a paper entitled Two Hundred and Fifty Cases of Syphilis Faultily Treated by Specialists.

## Book Reviews.

**THE JOURNAL OF EXPERIMENTAL MEDICINE.**  
Edited by William H. Welch, M. D., Baltimore. New York: D. Appleton & Co. Volume I, Number 1. January, 1896.

The first number of the *Journal of Experimental Medicine* has just been issued. In the introduction, coming from the pen of Dr. William H. Welch, the objects and tendencies of this journal are clearly outlined. As stated, original investigators in the various branches of experimental medicine have hitherto been obliged either to publish their scientific papers, often in condensed form and imperfectly illustrated, in periodicals devoted mainly to the practical branches of medicine, or to send them, as has become increasingly the custom, to various scientific journals of Europe. The Journal will hence meet a long-felt want in the United States and Canada.

If the old saying, "Tell me what you read and I will tell you what you are," be true, the financial success of the new journal will permit a direct insight into the intellectual status of our American medical profession. Of German journals corresponding in character to that of this new journal, a large number have a wide-spread circulation abroad. The *Zeitschrift für Klinische Medicin*, the *Deutsches Archiv für Klinische Medicin*, the *Charité Annalen*, *Virchow's Archiv*, the *Archiv für Experimentelle Pathologie und Pharmakologie*, and others, are read not only by the hospital physician and laboratory student, but also by the general practitioner. In our country, it is mournful to say, the average general practitioner still prefers the little journal which provides him with "unfailing recipes," and a startling description

of a case of "ulceration of the womb," to a journal containing the results of carefully conducted laboratory experiments. Let it be hoped that the *Journal of Experimental Medicine* will carry the American physician to a higher intellectual level, and may it not despair, if during the next few years the journal of him who did not succeed in the practice of medicine and therefore established a weekly bulletin of "just what we want to know," receives the preference.

The name of Dr. William H. Welch as editor-in-chief is a sufficient guarantee for the high standard of the work which will be found in the pages of the journal.

The names of the associate editors, collaborators and contents of this number have already been published in the MARYLAND MEDICAL JOURNAL.

The general topography of the work is satisfactory; a greater margin at the tops of the pages, however, would be desirable.

**THE MEDICAL COUNCIL;** A Monthly Journal for the Physician and Surgeon. Philadelphia: Dr. J. J. Taylor, Publisher, and Drs. J. J. Taylor and A. H. P. Leuf, Editors. Volume 1, Number 1. March, 1896. One dollar a year.

While this is not a specialists' journal it does pay special attention to those subjects most usually encountered by the general practitioner, such as obstetrics, gynecology, diseases of children and general improvement of the race. The *Medical Council* shows itself to be a very practical monthly which will find a hearty welcome from many a physician who is looking for help in his practice. The contributors to this first number are good men who have written especially for this journal and have said something worth remembering. The abstracts from recent literature give evidences of great care and judgment. Dr. Taylor is to be congratulated on his well edited and well printed monthly.

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#### REPRINTS, ETC., RECEIVED.

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**The William Pepper Laboratory of Clinical Medicine.** Address by John S. Billings, M. D., at the opening of the Laboratory.

**The Treatment of Uterine Retro-displacements by Vagino-fixation.** By Dr. Frederick Holme Wiggin. Reprint from *New England Medical Monthly*.

#### Current Editorial Comment.

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##### A HOSPITAL'S RESPONSIBILITY.

*The Medical Fortnightly.*

IT is a question of vital interest to a hospital to know just what is the responsibility it should bear for the acts of physicians who bring patients within its walls for treatment. It strikes us that like the editor who is not responsible for the utterances of contributors to his columns, the hospital should not be held responsible for the acts of its patrons. We are not indulging in what may be the law, but simply what we think is right.

##### CORPULENT POLICEMEN.

*Boston Medical and Surgical Journal.*

THE thought has probably occurred to many of our readers, as it has to us, on seeing some of the corpulent members of our police force on patrol, how easily an active crook could escape the pursuit of such a protector of our lives and property! The tendency to obesity and general decrepitude among policemen has been noted in other cities, and it is well that the effects of the inactive life of many policemen upon their effectiveness as officers of the law should be considered. Perhaps it would be a little too much to demand that our policemen should be kept in as good physical training as the members of a college crew or team; but their training might at least include long distance running, and there might be a weight limit. The reasons for these suggestions are sufficiently obvious.

##### IT IS GYN-E-COL-O-GY.

*Medical Council.*

PHYSICIANS should be particular to pronounce correctly the technical terms of the science. There is one word which is almost universally grossly mispronounced—the one used to designate the science of the diseases of women. It is generally pronounced gyn-e-col-o-gy, the "g" hard and the "y" with the long sound. This is entirely wrong. The root of the word is "gyn," not "gy." It is properly pronounced with the "g" soft and the "y" having the short sound, as if spelled "jin." Other words of like derivation are, gyn-archy, gyn-ocracy, gyn-ecian, etc. It always makes us feel discouraged to hear—even from the lecture stand and the rostrum—"gy-necology." Yet one can easily inform himself by looking it up in the Standard or Gould's Medical Dictionary.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### THE INDUCTION OF PREMATURE LABOR FOR OTHER THAN THE USUAL INDICATIONS.

READ BEFORE THE CLINICAL SOCIETY OF MARYLAND, FEBRUARY 7, 1896.

By *J. Whitridge Williams, M. D.,*

Associate in Obstetrics, Johns Hopkins University; Gynecologist to the Union Protestant Infirmary, Etc.

THE most usual indications for the induction of premature labor are either moderate degrees of pelvic contraction or progressive renal insufficiency. In the first class of cases, the operation is performed in the belief that a fetus at the thirtieth or thirty-second week may pass through a pelvis which will not permit the birth of a full-grown fetus at term. Induction of labor for this indication, it will be remembered, was first brought into practical use by Denman, and since his time has frequently been employed. Owing to the relative infrequency of contracted pelvis in this country, we do not resort to the operation for this cause nearly so frequently as do our continental confrères; and it would appear that the rehabilitation of the operation of symphysiotomy will restrict its employment to a certain extent even in Europe. Thus, Pinard, who is probably the ablest obstetrician in France at the present time, states that he no longer considers the operation justifiable in this class of cases, and resorts instead to symphysiotomy at full term. The Germans, on the other hand, still cling to the older operation in preference to symphysiotomy.

The most usual indication for the induction of premature labor, in this coun-

try, is progressive renal insufficiency. That is, cases of acute or chronic nephritis occurring during pregnancy, which, under appropriate treatment, become worse rather than better, and force us to choose between the dangers of a probable eclampsia or even death from the renal affection alone, and the induction of labor.

You also know that the operation is occasionally performed for various other indications, which threaten the life of the mother, and consequently that of the child also. Among these may be mentioned the uncontrollable vomiting of pregnancy, uncompensated lesions of the heart, and finally any disease which directly threatens the life of the mother.

During the past year, it has been my lot to meet with two cases which demanded the operation for other than the usual indications. The first being a case of acute dilatation of the heart, following mitral insufficiency; and the second, a case of acute pyelitis, which directly threatened the life of the mother.

I wish this evening to give you a brief history of the two cases, and to draw a few conclusions from them.

CASE I. *Induction of premature labor for acute dilatation of the heart.*—Mrs.

Margaret Voelker, aged 34, married 8 years, 3-para, oldest child born dead 7 years ago, youngest child 2 years old. Menses first at 17 years, regular, lasting 4 days, not accompanied by pain. Last menses the first part of May, 1894, making the expected date of confinement about the first part of February, 1895. Up to three years ago, her personal and family history was negative, but at that time she was confined to bed with acute rheumatism, the knees and ankles being the parts affected. The patient stated that she did not have any heart trouble at the time or immediately following it. The present pregnancy was perfectly normal up to the latter part of November, 1894, when she began to suffer from dyspnea, which, however, was not severe enough to render the services of a physician necessary.

On Christmas Day, 1894, she applied for aid to the out-door Obstetrical Department of the Johns Hopkins Hospital, and my assistant, Dr. Dobbin, saw her at her home. At that time she was suffering from broken heart compensation, and presented a somewhat dilated heart and a distinct mitral regurgitant murmur. There was some edema of the lower extremities. She was placed upon digitalis, and later upon iodide of potash and Blaud's pills and six days later was once more very comfortable. This continued until January 10, 1895, when Dr. Dobbin was called to her about ten o'clock at night and found her in a most serious condition. Her husband stated that he found her lying on the floor and gasping for breath, but she was unable to state how long she had been in that condition. As soon as Dr. Dobbin saw the patient, he sent for me, and on my arrival, I found her sitting up in bed and fairly fighting for air. She was intensely cyanotic and could hardly speak and stated that she believed she was in labor; but examination through the abdominal walls showed that it was not the case. Physical examination showed that the heart was laboring intensely and was beating from 150 to 160 times per minute. The heart was markedly dilated, the apex beat being more than three cm. to the left of the

nipple line, while the heart dullness extended beyond the right sternal margin. On auscultation, murmurs were heard at all the valves and there was marked edema of the lungs.

Several hypodermics of tincture of digitalis were given, as well as a considerable quantity of whiskey. In spite of this, however, the dyspnea was steadily increasing and the pulmonary edema becoming more marked.

As a last resort, I determined to try the effects of blood-letting and extracted about a pint of blood from the superficial veins of the right arm. This relieved her for a few minutes; but the symptoms gradually increased in severity and her condition once more became alarming, and forced me to choose between a second venesection and seeing the woman suffocate before my eyes. I accordingly bled her once more and allowed another pint of blood to escape. At the conclusion of the blood-letting she was able to lie down and after a short while fell into a light sleep.

The following morning the dyspnea returned and later in the day she was transported to the Johns Hopkins Hospital, where she was examined by Dr. Thayer, who confirmed the diagnosis of the evening before.

On her entry into the hospital she was fairly comfortable, with a pulse of about 120. Later in the evening her cough and dyspnea became more intense, and at 10.30 P. M. her condition had become so serious that Dr. Thayer bled her once more, allowing 415 cc. (1 pint) of blood to escape. During the night she received two doses of elaterium ( $\frac{1}{2}$  grain each), and the next morning, January 12, we determined upon the induction of premature labor.

At 10.30 A. M. we introduced under the strictest aseptic precautions a silk-covered bougie into the uterus. This failed, however, to set up uterine contractions and on the 13th we introduced another and larger bougie under the same precautions. This likewise failed in its object and on the 14th we introduced two of the largest size bougies. These at last caused uterine contractions to commence during the early morning of

the 15th. The uterine contractions continued very feeble until the morning of the 16th, when they gradually became stronger and at about 7 p. m. she gave birth to a large child perfectly spontaneously. The child measured 52 cm. in length and weighed eight pounds and two ounces. The child was in the left occipito-iliac anterior position and the labor, apart from its slowness, offered nothing of note. The entire duration of labor was occupied by the first stage, as the child was born by a single expulsive pain. The pelvis was normal.

The patient's condition continued fairly good until the 15th, when her heart showed signs of flagging and necessitated the use of digitalis. Immediately after delivery her condition improved and she was fairly comfortable. The puerperium was not entirely normal. On the second day the temperature rose in the evening to  $102.8^{\circ}$  and on the third day to  $103.8^{\circ}$ ; it then gradually decreased and reached the normal on the sixth day, after which it did not rise again.

Dr. Thayer, who very kindly saw the case with me several times, was inclined to agree with me that the rise of temperature was due to a lighting up of the old endocarditis, rather than to a puerperal sepsis.

Strength was lent to this supposition by the absence of all symptoms characteristic of puerperal sepsis, except the rise of temperature, and even here the short duration of the elevation speaks against its septic nature. All through the puerperium the uterus was very firmly contracted and at no time was there pain or tenderness in the lower part of the abdomen; there was no tympanites, nor were there any symptoms on the part of the lochia to indicate puerperal trouble.

On the third day of the puerperium, or the second day of the rise of temperature, the interior of the uterus was examined by the finger and found perfectly smooth and the uterus then douched with three liters of warm normal salt solution. The salt solution was perfectly clear when it escaped from the uterus and had absolutely no odor.

I regret that I was unable at this time to make cultures from the interior of the uterus, and I am therefore unable to state whether it contained micro-organisms or not, and consequently cannot prove positively that the elevation of temperature was not due to puerperal infection.

After delivery, except for the elevation of temperature, the patient's condition improved very rapidly and she was able to leave the hospital on the 12th day in very excellent condition. The heart had recovered its compensation and examination showed that the dilatation had almost entirely disappeared. The apex beat was still outside of the nipple line, but the heart dullness reached only to the left sternal margin, instead of beyond its right margin, as was the case previous to delivery.

The consideration of this case presents several interesting features. In the first place, the sudden onset of the acute dilatation is of considerable interest; and it is difficult to explain why the increased labor to which the pregnancy subjected the heart should have delayed until so late a period (the beginning of the tenth lunar month of pregnancy) before becoming manifest and breaking the heart's compensation.

I am inclined to believe that the primary blood-letting saved the patient's life and that she would have died had it not been done, even though we had emptied the uterus at once.

The beneficial effect of the blood-letting was almost instantaneous and we saw the patient drop off into a comfortable sleep, who only a few moments before had been fighting desperately for life.

It may be objected by some that it would have been more conservative to have dilated the cervix manually and promptly extracted the child, instead of subjecting the patient to the tedious induction of labor by the introduction of bougies. When first seen, the patient's condition was too desperate to think of such a thing; and after the venesects her condition improved sufficiently to obviate the necessity for rapid delivery; and as she was in the hospital and un-

der careful supervision, I considered the method employed the more conservative and the result showed that we lost nothing by our choice. At the same time, it must be stated that we stood ready to terminate the pregnancy at any moment by the most rapid method, should occasion have arisen.

Another important lesson taught by the case, which, however, is not a new one, is the tediousness and uncertainty of the induction of labor by this method and I should certainly not recommend its employment when immediate delivery is urgently indicated, but should prefer to resort to the manual dilatation of the cervix under anesthesia.

*CASE II. Induction of premature labor for acute pyelitis.*—Mrs. S., aged 30, primigravida. Last menstruation February 28, 1895; expected date of confinement December 7, 1895. Family and personal history negative. I first saw the patient June 10, 1895, when her mother consulted me about her condition and stated that she was about four months pregnant, and for the past week had been suffering with a great deal of pain in the lower part of the abdomen and was obliged to pass small quantities of urine almost constantly. From the history, I suspected that I had to deal with a retroflexed pregnant uterus and that the constant urination was the incontinentia paradoxica of the older writers. Upon examination, however, I found that the uterus was in normal position and corresponded in size to a four months pregnancy; a slight amount of pus could be squeezed from the urethra and the base of the bladder was sensitive on pressure. The urine was cloudy, with a specific gravity of 1016, and acid reaction, and, on standing, a dense white sediment was deposited, which under the microscope contained large numbers of leucocytes and a few epithelial cells. A diagnosis of acute cystitis was made and the patient placed upon copaiba and effervescing tablets of citrate of lithium. Under this treatment the symptoms rapidly improved and at the end of a fortnight the pus had almost entirely disappeared from the urine.

The patient then left town and a month later wrote me that she was perfectly well; and the chemical and microscopical examination of the urine, which she sent me at the same time, was perfectly negative.

All went well with her until the latter part of August, when she was camping out with her husband in the far West, when she was suddenly seized with intense pains in the left renal region, accompanied by chills and fever. She was immediately taken to Chicago, where she recovered sufficiently under medical treatment to be able to return to her family in Virginia two weeks later. Her physician in Chicago diagnosed a renal calculus. For several weeks she did very well, but was again seized with a similar attack, which did not yield to the treatment of her physician. Her condition grew rapidly worse and she was brought to Baltimore, and in my absence from town taken to the Hopkins Hospital, where she was treated by Dr. Kelly. While at the hospital, she suffered with intense pain in the left renal region and had hectic fever with occasional chills, accompanied by marked emaciation, and her urine was loaded with leucocytes and casts. An acute pyelitis was diagnosed, but owing to her generally poor condition no active treatment, such as catheterization of the ureters and irrigation, was attempted. By the latter part of September she had so far recovered from this attack as to be able to return to her home in the city, where she gradually grew better.

I was called once more to her on October 11, 1895, and found her writhing with pain in the left renal region, with high temperature and a rapid pulse, morphia being necessary to quiet the pain. During the next ten days, her condition became more and more serious, the pain still continued and was accompanied by hectic fever. She emaciated rapidly, was constantly nauseated and was steadily losing ground. Her urine at this time was loaded with leucocytes and contained many granular and hyaline casts.

After consultation with her physician, Dr. I. E. Atkinson, and Dr. Kelly,

it was determined that her only chance of life lay in emptying the uterus of its contents. We supposed that we had to do with an ascending process, which had started in the bladder and gradually made its way up to the kidney. We also considered that the gravid uterus, by pressure upon the left ureter, caused its partial obliteration, with subsequent retention of the pus within it and the renal pelvis.

Examination at this time showed that the pain was almost entirely limited to the left renal region, but no enlargement could be detected. The pelvis was slightly contracted, being of the generally contracted variety, with the following measurements: Spines 23 cm. crests 27, trochanters 31, Baudelocque 18 and oblique conjugate 12 cm.

The uterus corresponded in size to a pregnancy at the middle of the eighth lunar month. The child appeared to be of fair size and was in the left sacroiliac position.

Operation October 26, 1895. Owing to the patient's very weak condition, it was decided to attempt the introduction of the bougie without the use of an anesthetic.

The patient was placed in the dorsal position on a suitable table and carefully cleansed. But on attempting to introduce a speculum, it was found that the vulva was so small that it caused intense pain. Chloroform was therefore given, but before she had become completely anesthetized, her respiration ceased, and it was only with the greatest difficulty that she could be resuscitated. I then desisted from any further attempt at anesthesia and introduced a large sized bougie into the uterus in spite of the intense pain caused by so doing.

Uterine contractions commenced within twenty-four hours after the introduction of the bougie, but were very feeble in character and at the end of 48 hours the cervix had only dilated to about 4 cm. in diameter. I therefore decided to wait no longer, but to dilate the cervix manually and extract the child. With the kind assistance of my friend Dr. L. E. Neale, the patient was put

under full ether anesthesia and I dilated the cervix, brought down the feet and extracted a semi-asphyxiated child by the Smellie-Veit manevrue.

The perineum was so rigid that the mere introduction of three fingers into the vagina caused its rupture half way down to the anus, which was naturally somewhat increased by the passage of the child. While the perineum was being repaired, respiration ceased once more, but the patient was readily resuscitated. The child weighed five and a half pounds and was placed in an incubator, but died suddenly thirty-six hours after birth, from a heart lesion.

The puerperium was entirely normal, the temperature only once reaching  $100.4^{\circ}$  F. The pulse, which previous to the operation ranged between 110 and 120, gradually dropped and on the fourth day reached 80, and never afterwards rose higher than 85. As the puerperium advanced, the quantity of urine passed in the 24 hours gradually increased from 800-1000 cc. prior to the confinement, to 1800 cc. at the end of the first week. The patient's condition improved rapidly, she began to gain in appetite and weight and each examination of the urine showed marked improvement, the casts disappearing first and the leucocytes more gradually. When last seen, January 9, 1896, the patient had gained about twenty pounds and was in excellent condition; the urine contained no casts and only a few isolated leucocytes.

The consideration of this case and its result shows that the operation was urgently indicated and my only regret is that we failed to save the child. I am confident had we not interfered that the patient could not have lived to the end of the pregnancy and we should have lost two lives instead of one. The result of the operation appears to me to afford abundant proof of the correctness of our opinion, that the untoward symptoms were caused by the pressure of the gravid uterus upon the ureter with damming back of the pus, with subsequent infection, and that the pain was due to Nature's effort to overcome the obstruction.

# AN HISTORICAL INVESTIGATION BY DR. MORITZ COHN, HAMBURG.

TRANSLATED FROM MONATSHEFTE FUER PRAKTIISCHE DERMATOLOGIE.

By Robert B. Morison, M. D.,  
Baltimore.

WHO would not praise Hippocrates, but does every one read him? Fortunately from a good translation by Robert Fuchs, recently published, we can more easily understand him, and it is a pity that doctors, especially dermatologists, do not get more deeply interested in such a wonderful investigator as he was.

While we must respect Hippocrates for his sharp and acute chemical knowledge, we can also see that he knew very little of physiology and anatomy. For instance, he gives us the following description of the growth of the nails: "The nails spring from a jelly, it being a moist fluid separated from the bones and joints which is sticky. After this formation the heat of the body dries and hardens it. And this is the way the nails are formed." He counts the nails among the bones and only mentions eight bones in the skull.

More peculiar still is the idea which Hippocrates has of the hair. The longest hairs are found upon the scalp, because the largest gland—the brain—is underneath. He also thinks that the hair, like the nails, is from a jelly and in fact only grows upon such parts of the body where the glands are found. Animal heat is necessary for the growth of the hair and that accounts for its presence in the arm-pits and the pubes. It would seem a question where the necessary heat from the head came from, as the longest hair grows upon it. A thin skin is necessary for a thick growth of hair and therefore men are better off than women.

If children are castrated, they have no beard, because the epidermis, on account of the loss of semen, does not open the pores, nevertheless the eunuch has one advantage, as he never has a bald head.

The last remark seems founded upon truth, as the investigators have said that eunuchs are seldom bald.

In all of his books Hippocrates gives great attention to the sexual functions. As an example, if the testicle on the right side is cold and retracted, it is deadly. Further on he says, "the semen is sent from the entire body, the healthy from the healthy part and the diseased from the diseased part."

He pronounces as most unworthy of coitus the people of Scythia, because of their loose trousers, podagra, ischias, riding, and particularly their general coolness. Again he says if anyone frequently and persistently rides, he is generally attacked with an oozing, ischia and podagra, which renders him quite impotent.

It is quite remarkable the statement of Hippocrates that the color of a Scythian's skin is yellowish-red from the coldness of the air. On the other hand, many of his remarks about the skin are most admirable. Thus we read that the color is much influenced by the heart, especially where there is valvular disease. He says, "changes in the color of the skin happen if the heart opens or closes the blood vessels too much. If they be left open, the color will be red, beautiful and transparent. If they be contracted, it will become pale and wan. These changes are influenced by personal characteristics."

He speaks of an odor from the skin. That the sweat is salty because of its salty taste. That whether in sunshine or not, the clothed part of the body sweats, while the exposed part of the body dries very quickly. He seems to have been ignorant of the influence of moist air upon perspiration, but to have noticed the difference of the skin between the young and the old. He says:

"Skin changes as one grows older, whether one lives in a North wind or a South wind, but old age certainly makes a difference."

He knew of the cold sweating of the death-bed, for he says : " Those who have a dry, hard skin stretched over the body die without sweating, but on the other hand, those who have a thin skin die in a perspiration." Speaking of medical baths, he says : " Drinking water makes one moist and cold, as it gives moisture to the body. Salt water bathing makes one warm and dry, because, as it is naturally warm, it draws the moisture from the body. Warm baths in a delicate state weaken and cool the body, because the moisture of the body is taken off and the muscles

lose so much they are chilled. A person feels warm and moist after eating, because the fluids of the body are increased. Cold baths act in a contrary way; if they are taken on an empty stomach they stimulate you, but after a meal it is better to drink some fluid before taking one."

As an addition to these anatomical and physiological remarks, I give here the nomenclature of Hippocrates as follows : He speaks of ulcers, spots, whether white or black ; tumors, tonsilitis, inflammation of the genitals, warts of various kinds, pruritus senilis, hemorrhoids, etc.

In many ways Hippocrates must have seen many things which we of the present age do not.

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## SYMPATHETIC OPHTHALMIA ; RECOVERY.

READ BEFORE THE CLINICAL SOCIETY OF MARYLAND, FEBRUARY 7, 1896.

By Robert L. Randolph, M. D.,  
Baltimore.

By way of preface I should say there are no objective features about this case which would strike the general practitioner, but inasmuch as recoveries from this disease are exceedingly rare, and as this is the first case of the kind which has been brought before this Society, I thought it would be interesting simply to see one who has had such an experience. You all know that sympathetic ophthalmia is traceable to a penetrating wound of the eyeball ; that is to say, an eyeball is injured, irido-cyclitis follows and in a certain length of time, ordinarily from three to ten weeks, inflammation breaks out in the other eye and this inflammation is called sympathetic ophthalmia.

Sympathetic ophthalmia may be defined, then, as a plastic inflammation of the iris, ciliary body and choroid of one eye, having its origin in a traumatic inflammation of the same parts in the other eye. Injuries of this character, as a rule, destroy sight at once, or certainly in a very few days after the injury. Eyes, then, which have been

rendered sightless by penetrating wounds are regarded as dangerous eyes and liable to give rise to sympathetic trouble, and consequently they are removed. Such a course requires little deliberation on the part of the surgeon, but there is another class of cases seldom seen, where vision is preserved in the injured eye after the outbreak of the sympathetic inflammation, and the case which I exhibit here tonight belongs to this variety. Such a case calls for no little deliberation in its treatment.

This man came to the dispensary of the Johns Hopkins Hospital early last May. I found a penetrating wound of the upper and inner border of the corneo-scleral region and at the bottom of the anterior chamber there was a faint line of what appeared to be pus. The vision was reduced to the ability to count fingers at six feet. He was given the usual treatment in such cases—1 per cent. solution of atropine, to be used every three hours, and a compress bandage. He got worse, however, and returned in three days with the anterior

chamber nearly full of pus and only slight perception left. I performed paracentesis of the anterior chamber and fortunately there was no reformation of the pus. The condition went on to get better and in the fifth week after the accident he could count fingers at fifteen feet. He disappeared from the clinic and came back in four days with the complaint that he could scarcely see anything out of the right eye. An examination revealed a typical case of sympathetic uveitis. The media was so cloudy at this time that it was impossible to get a satisfactory view of the fungus. The vision of this eye was  $\frac{1}{200}$ , while that of the injured eye, the eye which had caused all the trouble, was still the ability to count fingers at fifteen feet.

If the left eye had been blind I would have removed it, but the fact that good vision was still present in it and the possibility of its becoming ultimately the better eye contraindicated any radical measure. There is a case on record where a man in just such a plight as this one lost the sympathetically affected eye and the exciting, or injured, eye, became the useful one.

There was no change in my patient until the end of the ninth week, when the injured eye became suddenly very soft and in the course of a few days light perception disappeared. There was no longer any necessity of keeping this eye and thinking that as the focus of the trouble it might still be sending pernicious impulses to the other eye, it was removed. Not long after this the sight in the other eye began to improve and now, nine months after the development of the sympathetic affection, he has  $\frac{1}{40}$  vision and can read some of the letters on the next lower line.

The prognosis in these cases must be given with a certain amount of reserve, for lapses are common. As a rule, however, a patient who goes a year without relapse presents conditions which justify a favorable prognosis. In the past twenty years there have been reported about eighteen cases of recovery from sympathetic ophthalmia. This case is interesting, then, not only because it is one of recovery from sympathetic ophthalmia, but because vision was preserved in the injured eye a considerable length of time after the outbreak of the sympathetic affection.

**EXTRA-UTERINE PREGNANCY.** — M. Pinard (*Académie de Médecine, Paris*) reports a case of extra-uterine pregnancy discovered at six months. Just prior to term the abdomen was opened and a live child removed. Walls of the cyst were sewn to the margins of the abdominal opening, the edge of the placenta being included in the suture. The cavity was filled with iodoform and salicycized gauze. The child weighed five and one-half pounds. The placenta came away piecemeal during the fourth and fifth week. In summing up, Pinard says: "In the first half of pregnancy, or when the fetus has been dead two months, the cyst should be treated as a malignant growth. When the fetus has been dead but a short time, he prefers the remote risk of suppuration to the certain one of hemorrhage. If the fetus is alive at six months, he delays opera-

tion till it is viable, which in extra-uterine fetation is not until the ninth month, the risk to the mother from hemorrhage being in nowise increased by waiting after the placenta is once fully formed. With regard to the child, deformities are frequent in extra-uterine pregnancy and are comparable to those in the children of primiparae, with little amniotic fluid and resistant uterine walls.

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**CONVENIENT ALBUMEN TESTING.** — Dr. A. C. Ewing suggests, in the *Medical Record*, this method of testing urine for albumen: Draw up into a small glass pipette or tube about an inch of the urine, let the finger remain tightly over the top and insert the pipette into nitric acid and draw up under the urine the same quantity of acid. The presence of albumen will show at the line of contact.

## Society Reports.

### CLINICAL SOCIETY OF MARYLAND.

MEETING HELD FEBRUARY 7, 1896.

THE 318th regular meeting of the Clinical Society of Maryland was called to order by the President, Dr. J. M. Hundley.

Dr. S. S. Stone was elected to membership.

Dr. J. Whitridge Williams read a paper on the INDUCTION OF PREMATURE LABOR FOR OTHER THAN THE USUAL INDICATIONS. (See page 379.)

Dr. L. E. Neale: It seems to me that the method of dilatation by bougies is rather slow for such cases, and if possible that the condition of the patient would permit, the result might have been brought about in an easier and more rapid way. In the case which I saw with Dr. Williams that had to be resorted to eventually after 36 hours delay with the bougie. I remember saying that it was best that woman should be delivered as soon as possible. I have had some small experience with the use of this instrument's working and have had at times to abandon the bougie, and placing the patient under an anesthetic to dilate and deliver. I remember that in Pinaud's clinic a little bag passed into the cervix and injected with hot water or air was very highly lauded. I have never used it, but it was highly considered there. In the use of glycerine, which has been advised, I believe the best authorities are now strongly opposed to such a thing. My own results have not been satisfactory. For my part, if the case called urgently for delivery I would, as soon as her condition demanded it, not delay for bougies, but dilate and deliver as fast as possible. I think much valuable time may thus be saved.

Dr. Williams did not mention one little point which I have always considered of great importance; that is the repeated introduction of the bougie in different directions and twisting it about between the membranes before letting it remain. I don't think the dangers of

rupture are very serious. All such measures, though, are very slow and liable to fail and there is no way of foretelling in which case they will succeed and in which fail. Where there is no cause for haste such measures would be applicable, but where such cause does exist more rapid measures should be employed.

Dr. W. H. Fedderman: I have a case on the same order as those related, which I should like to report. It was not an induction of premature labor, for it was after time. The woman, 27 years of age, had been pregnant seven times and lost all of her children. I first saw her on October 17, 1894, when she gave the following history: Was born in Richmond, married in January, 1888, and had her first miscarriage in July of the first year, caused by a blow on the stomach. The second miscarriage occurred in July of 1889, at six months, and without known cause. The third occurred in 1890, fetus six and a half months. Fourth in February, 1891, seven months. The fifth, February, 1892, eight months. And the sixth in February, 1893, at eight months. In none of these was the cause known. The mother was well developed and healthy in every way, of a nervous temperament, but not exceptionally so. Her physician at Richmond said he was at a loss to account for her condition and no one had been able to help him. There was no trace of specific history, but he had used such treatment on every occasion, only to have it fail, as did all other plans of treatment. The baby generally died about three days prior to delivery. Would have chills and fever preceding labor. She had menstruated until March, felt movements on August 13, and expected to be confined in December. Confinement did not occur until January, 1895, hence was over time, and the reverse of her previous cases. I watched her closely and had put her on specific treatment before I heard from Dr. Ellis of Richmond, when I changed it for a general tonic treatment. About the 27th, she began to get nervous and anxious, but finding everything normal I quieted her fears. On January 4, I

was sent for, but found no symptoms of labor. It was a vertex presentation and the cervix was soft. This condition went on until the 14th, when I was again sent for and told that she had the peculiar feeling she had experienced before and that she was sure the baby was going to die. I began to feel that the time for inaction was past. I gave her a dose of quinine and said I would return in two hours. At that time no pains had started and I gave douches and started digital dilatation. Pains came on, but not sufficient to effect delivery and I applied forceps and delivered a 12½ pound baby, which is living and doing well.

*Dr. L. E. Neale:* If anyone continues this discussion I would ask to hear their opinion upon the use of quinine to induce labor pains. My experience with it has not been very favorable.

*Dr. R. B. Norment:* In case of uterine inertia I have tried quinine nine or ten times, giving 15 grains at one dose and not repeated. I have never seen any results therefrom that would encourage me to use it again.

*Dr. R. M. Hall* related a case as follows: I have a case that has puzzled me recently and I relate it in hope of gaining some assistance. Three weeks ago I was called to see a woman of 40 years suffering with an attack of cholera morbus and found her in a bad condition. Appropriate treatment allayed the vomiting and purging, but when I saw her again she was complaining of severe cramps on the left side. Notwithstanding heroic doses of bromides and chloral I was only partially able to control the pains. The following night she slept very little on account of pain. In a few days these attacks ceased, but left her with a sensation of numbness on the left side. On getting up she would feel as if that side of her body was asleep. She complained of considerable disturbance of vision in both eyes and says that things at a distance appear smaller than usual, and I noticed that she contracted her eyebrows while looking at things. I had her eyes examined, but no disturbance in the visual field was discovered. A few days ago I discov-

ered that there was slight paralysis of motion. She can walk but has no control of the left side. The reflexes are all right. She can move her arms and legs when lying in bed very well and when pinched is just as sensitive in the left limb as elsewhere. Examination of the urine was negative. I am puzzled as to the character and site of the lesion. I have ordered massage and strychnia and she is improving, but this is the fourth week. All this seemed to come from an attack of cholera morbus and if anyone here can tell me the seat and nature of the lesion I should be glad to hear it.

*Dr. C. H. Jones:* I arrived too late to hear Dr. Williams' paper, I am sorry to say, for I have a case to report and upon which I would like the opinion of the members. It is that of a young woman, 24 years of age, married and pregnant for the first time. She has a marked double aortic murmur, without any history of rheumatism, scarlet fever, or any of the diseases that would produce the heart trouble. She is in good health and did not know she had a heart until a life insurance agent examined her and told her she might drop dead at any minute. What I want to know is this: whether it is advisable to wait for term, or to perform an abortion, or induce premature labor in the case. She is now pregnant nearly five months.

*Dr. J. W. Williams:* I would say in regard to this case that I think any interference would be unjustifiable. The less you do for her the better, unless she develops some other symptoms. I have seen several cases of marked heart lesion go through labor without any trouble and the heart cases, too, bear an anesthetic very well. There is no need to induce labor unless some emergency arises. In my first case we induced premature labor in order to take the strain off the heart. I should advise you to wait until the end of the pregnancy.

*Dr. L. E. Neale:* I can report a case which occurred one month ago, where the patient had both aortic and mitral lesions when she came in the hospital. Nothing was done for her and she had a

perfectly normal labor. I can recall a case, on the other hand, where there was no valvular murmur heard, but there was a very slow pulse and which proved fatal. It was a criminal abortion and she was taken sick on the train. She had several fainting spells. Labor was perfectly normal, but immediately after she went into a collapse and died. No post-mortem was made, so I can say nothing about the condition of the heart, but I suspect there was trouble with the muscular structure rather than with the valves. In Dr. Jones' case I should do nothing.

*Dr. W. H. Welch:* I am not an obstetrician, but I have recently looked up the literature on the subject of heart trouble and I noticed there the statement that patients pass through pregnancy and labor without any interference with the action of the heart in these cases. It is not clear why compensation should be broken in pregnancy. As regards the relative prognosis in aortic or mitral disease I think there is no question that the patient is more comfortable with aortic than with mitral trouble. A patient with aortic insufficiency may live out a long life of hard work, and the question has been raised whether they should be refused life insurance. When compensation is broken, however, they run a more rapid and fatal course than those of mitral insufficiency.

*Dr. J. Frank Crouch:* Speaking of broken compensation I would like to report a case that came under my notice. The patient was a young woman of twenty-four, pregnant for the first time. She was under the charge of one of my friends, and during his absence from the city I was called to see her. I found a well marked mitral regurgitation and considerable edema. Placed her upon digitalis and she went to the end of pregnancy without any disturbance of the heart at all. She went through a normal first stage of labor, but when the head came into the pelvis, she suddenly became cyanotic and presented some alarming symptoms. I was sent for to assist; pulse was 125 and she was in a grave condition. The question of anesthetics was raised and we decided to

give it. Chloroform was used and the heart seemed to grow stronger. The child was delivered by traction. Compensation was established and inside of twenty-four hours she was comfortable, but four months later she dropped dead. I have seen other cases of broken compensation occurring during labor. Fifteen months ago I was called to see a woman who was gasping for breath when I reached her bedside. She rallied under digitalis and went on, comfortable for two weeks, when she had another attack of dilatation. Labor was induced. She was delivered and since that time has had no trouble. I take it that in cases of well compensated valvular trouble it is unwise to interfere until compensation is broken.

*Dr. Randolph* related a case of SYMPATHETIC OPHTHALMIA, with exhibition of patient. (See page 385.)

*Dr. E. J. Bernstein:* I was called recently by Dr. Hall to see a colored man who had received an injury to his eye in June last. He had gone from bad to worse until he had only light perception and in the other eye had symptoms of sympathetic ophthalmia, I mean signs of papillitis, present. I removed the offending eye and his vision in the other improved. It was done only three weeks ago, though.

*Dr. W. H. Welch:* What were the anatomical lesions in this case? I believe ophthalmologists make a distinction between sympathetic irritation without anatomical lesions and sympathetic inflammation of the eye with changes in its structure. To what extent then were the symptoms in this case due to irritation and what to inflammation, and how far have the lesions retrogressed?

*Dr. Randolph:* Cases such as the one reported by Dr. Bernstein have been observed by Noyes, Milles, Frost and others, but they should not be regarded as examples of true sympathetic ophthalmia. As I have remarked, true sympathetic ophthalmia is a plastic uveitis, in other words an inflammation of the iris, choroid, or ciliary body, an inflammation accompanied with the usual symptoms of a plastic irido-cyclitis, with

which you are familiar. Dr. Bernstein's case should be called sympathetic papillitis, which, like sympathetic irritation, is a benign form of sympathetic ophthalmia. In both these varieties of the disease the sympathetic manifestation, as a rule, disappears entirely with the enucleation of the injured eye, while in true sympathetic ophthalmia such as the one I have reported the removal of the injured eye is followed by no improvement of the sympathizing eye. The improvement which was commenced in my case soon after the enucleation of the injured eye was probably a coincidence. In Dr. Bernstein's case the patient will recover normal vision, while in my case such a termination is impossible. In answer to Dr. Welch's question I may say that the anatomical lesions in the sympathetically affected eye consisted in two posterior synechiae at the lower and outer edge of the pupil and opacities in the vitreous body and now that the media are clear enough to permit a view of the eye ground, there may be seen widespread changes in the choroid, consisting in pigment deposits, chiefly in the region of the papilla and numerous whitish areas of degeneration.

H. O. REIK, M. D.,  
Secretary.

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### Medical Progress.

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**LOCAL TREATMENT OF LARYNGEAL PHthisis.**—Kuttner (*British Medical Journal*) strongly pleads for the more active treatment of laryngeal phthisis. He gives short details in which three patients were well three and four years after curetting, laryngo-fissure having been previously done in one case. The state of the lungs improved considerably in two cases, and to a less extent in the remaining one. Further, a case of pharyngeal tuberculosis healed after repeated scraping and the application of the galvano-cautery and lactic acid. In two other cases the patients were in good condition eight months after incisions were made into the infiltration and lactic acid rubbed in. In the first instance

efforts were made to cure the disease by the application of disinfectants, and then by the removal of the diseased tissue as far as possible. The author only uses powders when there is abundant secretion, and cleansing inhalations are always employed before the application of any remedy. Lactic acid is to be used in cases where there is ulceration. If the above means do not answer, then incision, curetting, the galvano-cautery, electrolysis, tracheotomy, laryngo-fissure remain. With high temperature or advanced pulmonary disease, these measures cannot be recommended except to save life. Incision may be practiced in hopeless cases where a few foci of infiltration are present. In some cases, curetting gives good results, but all diseased tissues must, as far as possible, be removed. The galvano-cautery may supplement the curette, but larger bits of tissue should be cut off rather than burnt away. Tracheotomy has been of service even in cases where there was no danger from laryngeal stenosis, perhaps owing to the rest which it affords the larynx. The author thinks that in some cases laryngo-fissure is to be preferred to the endolaryngeal use of the curette, especially in cases where the disease lies in the posterior wall of the larynx. Besides the case above referred to, the author has performed thyrotomy in three other cases. One of these cases died a few weeks after the operation from pneumonia, but the two others lived for over a year.

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**CANTHARIDATE OF POTASSIUM IN THE TREATMENT OF TUBERCULOSIS OF THE WRIST.**—In the January number of the *Annales de dermatologie et de syphiligraphie*, says the *New York Medical Journal*, M. Gaston Brauthomme gives an account of the following case: The patient was a shoemaker, thirty-six years old. He was attacked with cutaneous tuberculosis in the upper part of the right hand and the lower part of the wrist. The author practiced *raclage*, which, however, proved insufficient, for a relapse occurred. He then resorted to the use of cantharidate of potassium.

On the 21st of May the urine contained

no albumen, and the author began injections with the following liquid:

Cantharidate of potassium, 0.0015 of a grain; Cocaine hydrochloride, 1.5 grain; Distilled water, 150 grains.

Eight injections of a cubic centimeter each were made up to the 4th of June; another of two cubic centimeters was given on the 12th of June. The punctures were rather painful and an abscess formed around one of them.

The first two injections were followed by a rise in temperature to  $103^{\circ}$  and  $102.1^{\circ}$  F. There was a local reaction which manifested itself by a rather copious exudation. This, however, did not occur at the third injection and cicatrization took place very rapidly.

At no time, says the author, when the urine was examined was there any trace of albumen found. At the present time cicatrization is perfect and the patient is in excellent health.

\* \*

**TREATMENT OF FAVUS.**—J. Khrenitchev of Kniajevatz, Servia (*British Medical Journal*), draws attention to the following method, which he has successfully resorted to in eleven consecutive cases of favus (all in soldiers). The head is thoroughly cleansed with a solution of potassic soap; then, after shaving (which in the case of an abundant hair growth should be repeated every other or third day), the following mixture is freely applied: R. Acidi carbonici, balsami Peruviani ää, 10 g.; petroli, glycerini ää, 100 g. M.

\* \*

**THE UNTRUTHFULNESS OF MORPHINOMANIACS.**—The mental and moral destruction which occurs in a victim to the morphia habit, says the *Medical Press and Circular*, is a fact which unfortunately has been only too frequently demonstrated. This point has led to some discussion respecting the expediency of rejecting the testimony in a court of law of those who are known to be addicted to the use of morphia. One authority has even gone so far as to say, "I would not believe a man who is a victim of the morphia habit on oath." No doubt the moral obliquity as to truthfulness present in such a person

would be perfectly uncontrollable, under any circumstances, and unrestrained, even although he had sworn to tell the truth. But before coming to any definite decision upon the question of receiving or rejecting the evidence of such a witness, it would first of all be only expedient to determine what constitutes a person whose mental and moral capacities have been tainted by the use of morphia.

\* \*

**ENDOMETRITIS.**—Winckel (*Wiener Med. Woch.*, No. 27, 195) says: In endometritis exfoliativa there is never any infiltration, as has been asserted. Between the shedding of one membrane and the development of the next there may not be the slightest trace of a discharge. Tuberculosis of the endometrium is rare, the tube being the seat of tuberculosis of the female genitalia; gonorrhreal endometritis is very frequent, and the gonococcus travels not only by the endometrium to the tubes, but also by the lymphatics to the peritoneum. Recent literature records no instance of the true diphtheritic endometritis. The well-known septic puerperal type is chiefly set up by streptococcus pyogenes aureus. Purulent senile endometritis is saprophytic.

\* \*

**PRURITUS IN PREGNANCY.**—Kolbachenko (*British Medical Journal*) reports that a very nervous woman, aged 25, complained of pruritus about the hypogastrium during the ninth month of her second pregnancy. The affection rapidly spread all over the body without any alteration of the skin. Labor was normal, and the itching ceased directly after delivery. The liquor amnii was turbid and yellowish-green in color, so that the pruritus was possibly septic.

\* \*

**SERO-THERAPY IN SYPHILIS.**—Hericourt and Ch. Richet (*American Medico-Surgical Bulletin*) report that they had treated by injections of serum a case of tertiary syphilis. The serum employed was taken from an ass who had received 20 ctm. of blood from a patient who had syphilis in the secondary stage. Cure was complete in four weeks.

MARYLAND

## Medical Journal.

PUBLISHED WEEKLY.

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BALTIMORE, MARCH 14, 1896.

WHILE medicine is not strictly a business, yet as time goes on there are many ways in which it is desirable to *Physicians' Offices*. treat it as a business.

One custom which is gaining foothold in several of the larger cities is that of having doctors' offices in large business buildings and this certainly has advantages, as a correspondent to the *New York Medical Journal* has shown. Chicago has one or more such buildings and of late New York has opened a new building, which is in part fitted up for the use of physicians. The advantages of such an arrangement may be best stated in the letter above referred to. The correspondent says:

"One of the advantages is that of removing one's work in great part from contact with one's family; women like this especially, as there is an impersonality about a great office building nowhere else obtainable; moreover, the physician obtains quarters in a splendidly fitted building, with surroundings equal to those of many a palace. In the

great insurance company buildings the wood-work alone is of the highest order. It should be saving of money, as one can live in a more modest home and not as his business increases swell out into larger establishments, such 'swelling' being the downfall of many medical men financially.

"There is an ethical consideration; the 'great' physician with an immense income does not do as good medical work as the man that earns much less, other things being equal as to education and natural ability. The laity think the opposite, and if they find a physician's office crammed full of patients, he is their man. Now, the coming practice of medicine is to be in a large part the more careful handling of chronic diseases; such handling takes time, and as soon as the laity realize that a physician will do better work who manages but a few patients, the better it will be for all concerned. The aggregation of doctors in a first-class office building will tend toward this desirable end. Working on a common level, medical men work altogether too long each day, and live altogether too short lives. To go home from the office and know that a great part of the day's work is done and that one will not have to labor away into the evening is a fine thing. Educate the people to know that, except in case of emergency, which we are always prepared for, the office work is to be done at certain hours in one place and the doctor will have more rest and time to see his family, bring up his children in the way they should go and receive the admonitions of his wife.

"Other advantages are a fireproof and carefully watched building and good attendance as to cleaning.

"The only objection is the necessity of two addresses. It seems to me that special arrangements could be made whereby telegrams received after office hours would be forwarded by the superintendent to the homes of the persons addressed. I wish to say one word as to so-called waste of money in the great insurance company buildings; from my personal observation down town, I believe that the insurance companies have invested the money of the policy holders most wisely; 'the best is the cheapest'; they have used the best as to material, and have not hesitated to get enough light and air. This can not be said of some buildings put up by rich men for investment; they have scrimped so as to

material and space that their investment I think does not pay as it otherwise would.

"Finally, all hail the day when medical men will not be in contact with patients more than eight hours a day."

\* \* \*

AT the risk of harping on one subject too much, attention is again called to the importance of having the *The Health Department.*

right sort of material in the health office of Baltimore, not only for the city, but as a port of entry for the whole State. All right-minded persons who are without political or party bias must admit that the Mayor of Baltimore is trying to do what is right and the "hitch" seems to be the appointments at the quarantine station and in the health office.

The civil service reformers must admit that it is better to retain in office those with at least the experience which has been gained by years of service, rather than put in men who may be politically orthodox but who are not able to recognize the dangerous diseases. The present officers have gained what experience they possess from years of service at the expense of the city and it would seem to be very poor economy to part with them at a time when their experience which has been paid for by the city may at any time be of inestimable value to the whole community.

If the city puts men in office and trains them to be thoroughly conversant with their duties after years of service it looks as if their removal for mere political reasons was poor policy. On these grounds alone, if on no others, the city should hold on to the officers in charge of the city health office and the quarantine station. If the profession of the city of Baltimore and also those physicians of Maryland who have the good of the State at heart would only look at this question as if their own families were at stake they would soon decide that the men with experience should be retained. The city health department now has a chemist and it is likely that a bacteriological laboratory will be added as soon as the appointments have been decided on.

An example of public spirit is seen in the case of some citizens of New Jersey who, with Dr. Charles E. Greene at their head, gave the necessary money for a State laboratory after the State Legislature had refused an appropriation for the purpose. If individual members

of a State or city take enough interest in the health of the community to give money to it, the citizens, and more especially the profession, should care who is at the head of the health department.

The Mayor of Baltimore is trying to act conscientiously and at the present writing no decision has been reached and every physician of whatever party should see to it that he gives his aid to secure the best health government for the city and the State.

\* \* \*

ALL States, without respect to geographical situation, are beginning to see the importance of having a suitable home or *Hospital for Consumptives.*

Two separate organizations in Maryland have made moves in the direction of establishing places where consumptives may be specially treated, but as yet nothing has been accomplished. Incipient cases are treated in the country at high altitudes and with individual attention, but cases which are doomed do better in large cities where they may be in reach of every attention and where their fatal end may be made as free from pain as possible.

It is not easy to persuade consumptives, the most hopeful of all those who are sick, to leave their homes to go to high altitudes. A consumptive who was sent away from the city once said that he would rather die in the city than live to be as old as Methusaleh in the country, for while in the city the consumptive got everything except air, in the country he got nothing else.

The outdoor treatment of consumption gives promises of the best results, but the home treatment is not without its advantages and those about to build homes and hospitals for the treatment or extermination of this disease should carefully consider this point.

The bill before the Legislature of Maryland looking to the registration of all consumptives is intended to restrict, as far as possible, this disease by an intelligent but not inquisitorial supervision and this has an educational feature in it, for the families in which occur such dangerous cases will receive literature showing how to avoid contagion and if it is so desired a health department inspector will visit the house, distribute literature and give such advice as will not conflict with the work of the attending physician.

## Medical Items.

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We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending March 7, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		30
Phthisis Pulmonalis.....		23
Measles .....	32	3
Whooping Cough.....	1	3
Pseudo-membranous Croup and Diphtheria. }	10	5
Mumps.....	1	
Scarlet fever.....	8	1
Varioloid.....		
Varicella.....	1	
Typhoid fever.....	4	3

Virginia has a State Board of Health.

The Medical Journal Club held its banquet last Saturday night.

The death of Dr. Marshall of the Eastern Shore is announced.

The Tri-State Medical Society will be held in Chicago, April 7, 8 and 9.

Dr. J. H. Ripley, a prominent physician of New York, died in Florida last month.

The International Congress of Dermatology will be held in London from August 4 to 8.

Dr. Duclaux has been appointed Director of the Pasteur Institute and Dr. Roux Sub-Director.

The Bay View Board has elected Mr. E. H. Perkins President and Dr. Harry Friedenwald Secretary.

The Medical Society of the Woman's Medical College passed suitable resolutions on the death of Dr. J. Edwin Michael.

A judge has decided at Battle Creek, Michigan, that a physician must testify in regard to the ailments of his patients.

The euphonious cognomen, Dr. Smith, is the popular monosyllabic appellation of 1300 practicing physicians in the United States.

Dr. Henry J. Berkley recently delivered lectures before the Philadelphia Pathological Society and the Philadelphia Neurological Society.

The city of Montreal was recently fined \$500 at the instance of the health authorities for having useless sanitary apparatus in the City Hall.

Dr. Godfrey Hunter has been elected senator to represent Kentucky. The United States Senate now contains two physicians, both Republicans, and one homeopath.

Dr. Augustus McShane has retired from the editorship of the *New Orleans Medical and Surgical Journal*, to be succeeded by Dr. Charles Chassaignac and Dr. Isadore Dyer.

Philadelphia is soon to have a large office building devoted exclusively to the use of physicians, to be known as "The Clinic." Cincinnati and New Orleans have such buildings in successful operation and New York is also contemplating a similar project.

The Duluth Gas and Water Company has been indicted for manslaughter in having caused the death of Harry W. Smith by typhoid fever, alleged to have been contracted from water delivered through the mains. Their franchise specifies that they shall furnish pure water. The outcome of the case will be interesting, as it will also apply to the responsibility of municipalities in like situations.

In New York the exposure, in front or within a store, of fish, game, meat or poultry is prohibited under a penalty of from \$100 to \$500. A law of this kind should be in operation in every State, that the dangerous practice of decorating the exteriors of markets with quarters of beef and the carcasses of lambs, calves, pigs and poultry, where they are exposed to undue heat much of the time and to the bacteria-laden air all the time, should cease.

The Berlin medical societies have taken up the question of the so-called "wild polyclinics" institutes under the direction of private physicians that are cropping up all over the city and where patients, rich and poor, can have medical attendance for nothing. It has been calculated that about 300,000 cases a year are treated gratuitously, and it is alleged that a large percentage of these are well-to-do people, fully able to pay. Of course this represents a tremendous loss to the Berlin doctors and it is no wonder that the medical bodies are beginning to agitate for legislation on the subject.

## WASHINGTON NOTES.

From the Health Department we get the following report for week ending February 29, 1896. Weekly mortality: Apoplexy 7, bronchitis 6, congestion of lungs 3, consumption 19, convulsions 3, diarrheal diseases 1, diphtheria 1, diseases of brain 4, diseases of heart 8, diseases of kidneys 5, malignant growths 4, measles 6, pneumonia 23, scarlet fever 2, suicides 2, typhoid fever 3, miscellaneous 40, la grippe 2, total 139. The number of deaths that occurred in the District during last week was 139, with a death rate of 26.23. In the corresponding period of last year the mortality was 133, with a rate of 25.26. As usual at this season of the year, the principal causes were affections of the lungs; nearly 14 per cent. of all who died had consumption and almost 40 per cent. of all the deaths were caused by diseases of the pulmonary organs. During the week the most prominent of the contagious diseases was measles. Of diphtheria, 8 new cases were reported, 11 houses discharged from quarantine and 16 remained in quarantine. Of scarlet fever, 5 new cases were reported, 7 houses were released from quarantine and 13 houses remained placarded. Hospitals reported 25 deaths and the coroner certified to 8 deaths. Births reported numbered 78 and marriage certificates filed were 20.

The Clinico-Pathological Society held its regular meeting on Tuesday, March 3. Dr. G. R. L. Cole read the paper of the evening entitled, "Report of a Case of Osteo-Myxochondra Sarcoma."

The regular weekly meeting of the Medical Society of the District of Columbia was held on Wednesday evening, March 4, the President, Dr. Samuel C. Busey, in the chair. Dr. George Borrie read an essay entitled, "The Clinical Significance of Renal Casts." The paper was discussed by Drs. W. W. Johnston, A. F. A. King and Robert Reyburn. Dr. F. B. Bishop read a paper on "Cerebral Hemiplegia; its Differential Diagnosis and Rational Treatment." It was discussed by Drs. G. N. Acker and J. Ford Thompson. Dr. S. S. Adams reported a case of "Convulsions from a Piece of Glass in the Stomach."

The Washington Gynecological and Obstetrical Society held its regular meeting on Friday evening, March 6, the Vice-President, Dr. S. S. Adams, in the chair. Dr. H. L. E. John-

son presented a specimen of diseased (cystic) ovary and tube. The woman had a history of gonorrhea and he showed the specimen, as it was pertinent to Dr. Scott's paper on "Gonorrhea in Women," read at the last meeting of the Society. Dr. I. S. Stone presented specimens of fibroids of uterus, removed by abdominal hysterectomy, and also a vermiform appendix. The specimens were preserved in formaline solution. Dr. Stone objected to formaline and thought a 5 per cent. chloral solution better. Dr. J. Taber Johnson presented a fibroid of the uterus removed by abdominal hysterectomy. The hemorrhages had been so severe as to cause fainting on several occasions. Dr. J. W. Bovée presented specimens of (1) tubo-ovarian cyst; (2) ruptured tubal pregnancy—the fetus was present and appeared to be about a seven weeks' gestation. Dr. Bovée said that he preferred formaline for a preservative, but suggested that it be a  $\frac{1}{2}$  per cent. strength. Dr. I. S. Stone read the paper of the evening, entitled, "Post-Operative Results in Pelvic and Abdominal Surgery." It was discussed by Drs. W. S. Bowen, F. S. Nash, W. P. Carr, H. L. E. Johnson, J. Taber Johnson, J. W. Bovée, J. T. Kelley, J. F. Scott, S. S. Adams and G. W. Cook.

The Faculty of the Post-Graduate School of Medicine, which has existed under the Charter of the District of Columbia, held a meeting on March 5 and reorganized under the new charter that has been granted by Congress.

## Book Reviews.

**AN AMERICAN TEXT-BOOK OF OBSTETRICS FOR PRACTITIONERS AND STUDENTS.** Richard C. Norris, M. D., Editor; Robert L. Dickinson, Art Editor. Royal 8vo., pp. 1009. With nearly 900 colored and half-tone illustrations. Price \$7.00, cloth; \$8.00, sheep; \$9.00, half Russia. Philadelphia: W. B. Saunders, 1895.

Considered as a whole, the work is a very good one and possesses as few faults as possible for a work of heterogeneous authorship. It will be very useful to the busy practitioner, who is pressed for time and is unable to read the current French and German obstetrical literature; as it offers an excellent résumé of the more recent advances in obstetrics throughout the world. The work is profusely illustrated and many of the illustra-

tions are original and improve greatly on those usually found in text-books.

The chapters on the anatomy of the generative organs and the physiology of pregnancy, which are contributed by Piersol, are the best with which we are familiar in English and leave very little to be desired. The only criticism which we would make upon his work is that he has practically based all his embryology upon that of the chick, instead of the recent work of Graf Spee, Selenka and Mall upon the monkey and man. We would also commend the clear manner in which Dickinson has treated the complicated question of the lower uterine segment.

Jewett's chapter upon the conduct of normal labor is likewise to be commended, especially the portion in which he considers the question of asepsis and hand disinfection. For it is the only chapter in the American text-books, which are usually recommended to students, which gives this most important subject anything like the attention it deserves.

The chapters of Reynolds on the mechanism of labor and Garrigues on puerperal infection are also deserving of praise. The work is, of course, not perfect, and numerous mistakes and inaccuracies may be discovered; but taken all in all, it is a valuable work and a very great improvement on its sister work, *The American Text-book of Gynecology*.

#### REPRINTS, ETC., RECEIVED.

*Practical Urethroscopy.* By H. R. Wosidlo, M. D. Reprint from the *Medical Record*.

*Rational Treatment of Pertussis.* By Francis T. B. Fest, M. D. Reprint from the *Journal of the American Medical Association*.

*The Treatment of Typhoid Fever by Intestinal Asepsis.* By A. L. Benedict, A. M., M. D. Reprint from the *Boston Medical and Surgical Journal*.

*Excision of the Coccyx for Constant Pain resulting from an Ununited Fracture.* By Lewis H. Adler, Jr., M. D. Reprint from the *Medical News*.

*Purulent Rhinitis, with Especial Reference to Chronic Empyema of the Ethmoidal and Sphenoidal Sinuses.* By John R. Winslow, M. D., Baltimore.

#### Current Editorial Comment.

##### PROFIT FROM DISCOVERIES.

*Kansas Medical Journal.*

We cannot help feeling that every investigator should be accorded all the emoluments and benefits arising from the results of his own efforts till such time as he sees fit to give them to the world. We believe that when a physician whose honor and integrity is unquestioned can demonstrate to the profession that he has accomplished a great undertaking, that he should not only be allowed to retain his secret, but he should also receive their support. If we insist that the world should have the benefit of our labors, then let the government make provision for a just remuneration.

##### STOP KILLING THOSE GERMS.

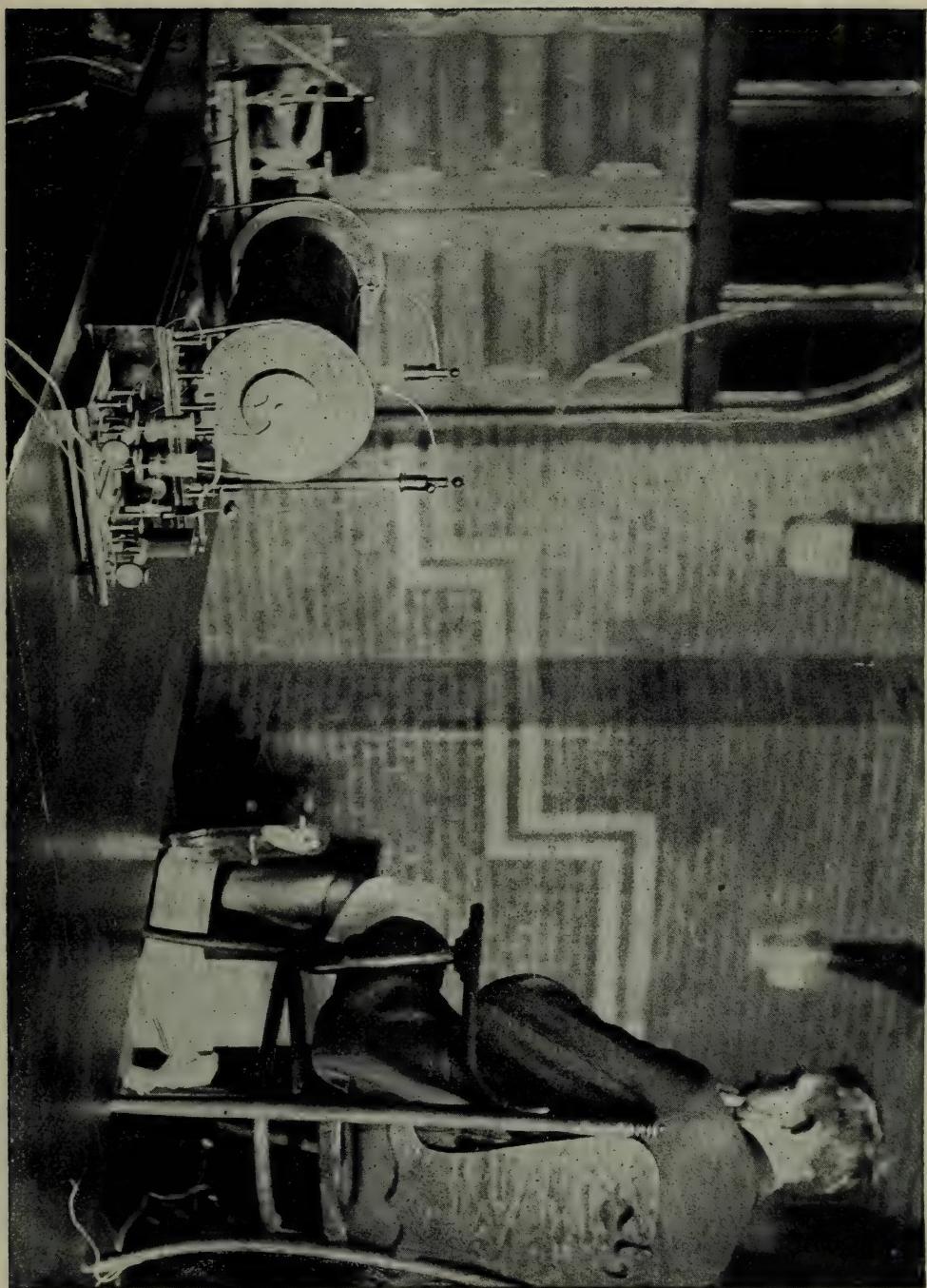
*Fort Wayne Medical Journal.*

ANIMALS fed upon sterilized foods, given sterilized fluids to drink and sterilized air to breathe, are now said to die with reasonable promptness. Babies fed upon Pasteurized milk get scurvy and become constipated. Give us more germs by all means. Make the indiscriminated sale of germicides a misdemeanor punishable by imprisonment and deprivation of germs for thirty days unless life is seriously imperiled by so long an abstinence. Let us eat, drink and breathe germs galore. Then will the white-winged dove of peace hover over health and home and bucolic health shall gladden the hearts of the sons and daughters of men.

##### SENSATIONALISM.

*Pacific Medical Journal.*

SENSATIONALISM is not by any means confined to the modern newspaper as many would make us believe, nor is it limited to morbid and abnormal literary and theatrical experiments, but in the realm of science devoted to the search for exact truth we find that there is a like tendency to cater to the masses through sensational means. We need not specify examples, many such must occur to the minds of every thoughtful person. It is enough that the facts are as stated. If we follow up this line of thought we might easily show how the cultivation of this abnormal desire for excitement has been a potent cause for the development of disturbance of a physical and psychical nature during the past thirty years.



LOCATING A BULLET IN A PATIENT'S LEG.



PHOTOGRAPH OF THE HAND SHOWING SESAMOID BONES.

# MARYLAND MEDICAL JOURNAL

A Weekly Journal of Medicine and Surgery.

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## Original Articles.

### OUR PRESENT HOSPITAL SYSTEMS.

By Arthur D. Mansfield, M. D.,  
Baltimore.

It seems to me that the time is propitious, aye, mandatory, when ignorance should be dispelled and the truth given light how charity (so-called) is dispensed in our hospitals and free dispensaries, and what class of people frequent our charitable institutions. Naturally the first question that presents itself to one's mind is "What is charity?" In its true meaning charity is noble; the fact of doing something for those who cannot help themselves is as elevating and ennobling as anything possibly can be; aiding and alleviating the sufferings of our human kind and fellow-beings is in itself workings of a higher nature, but anyone that has been associated with hospitals and free dispensaries cannot deny the fact that charity is but a mockery and a perversion. We all recognize this, we all know that it is so, yet why does it exist?

It always has been a surprising thing to me why medical men will toil and attend free those whom they know to be able to pay. Charity succinctly defined is "liberality to the poor;" then the question arises, who are the poor? Are they poor who dress well and ride in carriages? Are the poor those who are employed by the police force and by our cities? Are they poor who own houses and vessels? Are they poor who wear diamonds and sealskins?

And yet all of these classes have been seen in dispensaries seeking aid; and were they refused? No, gladly are they taken, that thus hospital reports may be enlarged and amplified and the institutions and the heads lauded as noble and large-hearted and toasted as great and good. When such exists (and it does) then charity is a mockery and "helping the poor" only a cloak wherewith men, women and children are taught that something can be had for nothing and the price paid is a stunted and a blunted conscience, a dear price; and the result an increasing list of paupers and ever-growing communism.

Some medical men devote themselves to the study of topics that have little or no bearing upon the practice of medicine among their patients. We hear society papers that theorize and reason in this way and in that, but as for practical bearing there is none. How many of my medical readers have listened to long excerpts and extracts from literature that has been gone over and over again many times and then we wonder why our societies are so thinly and sparsely attended and when something really of vital importance comes to our attention, the paucity of the members are of such a character as to dampen natural and inborn ardor. I bring before you, my reader, you individually, a subject

in which you have as much vital interest as I have. Awake from your lethargy; it is never too late to do good, but always too late to repair an injury and undo a wrong. Wounds always leave a scar, even when healing by first intention. Men say, what is the use of objecting? I say, no use, if our objecting stops with our thoughts, but every use if we act.

Should people receive gratuitous treatment at our hospitals if they are able to pay? Will any say other than nay? Well, they do. Don't you believe it? Enquire for yourself and you will soon find out. Who is to blame? I mince no words. In my opinion those that are to blame are clearly and distinctly marked. For seven years I have been studying this question, have seen it growing as a vile octopus, stretching its venomous tentacles into every avenue and into every interstice of our professional and social existence; it grows and is growing steadily and surely, encouraged and fattened in strength by the lethargy and indifference of the various causes that produce it, very much like the parasites we see growing upon animal and vegetable hosts; the parasite grows and strengthens at the expense of the one that gave it infantile nourishment. So with our perverted charity hospitals, so-called free dispensaries for the poor; they rob the men of a living that make their existence a possibility, they enrich some few, but what proportion do they bear to the large number that are striving and struggling for a living, and yet medical men say that medicine is not what it used to be. Of course it is not and never will be so long as there is a social factor at work in our midst that is daily, even hourly, pauperizing the existing community and teaching children that know not their alphabet, that to obtain something for nothing is better than getting something by an effort.

But, to return to the subject, the causes that have produced this present condition are three-fold: In the first place, the most blame is directly attributable to those having authority over our hospitals. I refer to the financial di-

rectorate of our hospitals as well as to the surgical and medical heads. Under this class come philanthropists who, out of the goodness of their hearts and for motives best known to themselves, give largely to our hospitals and have correspondingly as much say in the management of the same. Connected with these we have a host of friends and lesser philanthropists who compose our so-called managers, directors, trustees, or what not, and these feel it incumbent upon themselves to recommend to the hospitals for treatment all they know who are willing to come and by means of the inside "pull" they have on the working staff, slide these worthies through quickly and with extra attention, while the poorer and more deserving element is made to await the pleasure of these "spongiers" who, when entering hospitals and dispensaries, think they are conferring a great honor on the institution and woe unto the man who dares question such as to their ability to pay, or whether they should not go to a private office. He will be told point blank by the "worthy" that he or she gives one dollar a year to the institution (for aiding the poor) or that Mrs. A. (who works for the temporal welfare of the institution) "told me I could be treated free if I gave a can of corn or a bushel of potatoes, which I have done."

If the surgical and medical authorities should say that none could be treated free who are able to pay, this state of affairs would not exist. I feel that the greatest blame is at their doors, for you might knock in vain at the doors of our charitable institutions—if the porter refuses you admission when and how can you be treated, I would like to know? And how long would it be before the ones seeking aid and able to pay for it would cease asking? The reason so many are to be found in our hospitals that can and would pay is because they can open the door, walk in and be treated without question. The lay public know that they can get any treatment they want for nothing, even to medicine furnished, thus robbing, at the same time, medical men of an honest and honorable living and depriving druggists and phar-

macists of a competency that justly belongs to them and we wonder why they prescribe across the counters. Men are not going to starve for a mere flimsy code of ethics laid down by other men of an effete age and having a sufficiency of this world's goods to keep them from worrying as to how to clothe themselves and provide for their families. We live and move among the people about us, which is the mediocre. The majority of medical men make their living amongst those that earn their living and not amongst those who have nothing to do but spend money. After all, the middle class (so-called) of society is the largest and forms, at a conservative estimate, 60 per cent. of the hospital and free dispensary attendants.

Secondly, the profession at large, both medical and ecclesiastical divines, is to blame to a proportionate degree. Doctors think they are doing a very charitable thing when they send patients to hospitals for treatment. They are not just prepared to give such treatment as fitting glasses, controlling a discharging ear, or for operations of one kind or another that they do not feel able to do or not prepared to do, not having the proper instruments or appliances. Professional men generally are addicted to this method of dispensing charity, it being very easy to give charity when someone else pays for it. It is easy to tell the patient what grand good doctors are at such and such an hospital or dispensary, never once realizing that the doctors do not live in the hospitals with their families like so many military officers at a fort or academy and are supported by the government, but they think that the goodness and nobility of their magnanimous hearts are put on and off with their hospital garbs and that the air in hospitals and dispensaries revives all the divine attributes of nobility, goodness and ability that are indigenous to higher beings known currently as angels. These same doctors are at their offices with the same flesh and blood, the same brains and nerves, and the same abilities, trying to make an honest living, while their fellow men are doing everything they can to keep

them from it. How many men send patients to offices of men good enough to work in hospitals, with a request that charity be exercised and the patient be allowed to pay what he can?

There is a prevalent idea that specialists charge exorbitant fees. This idea is simply born of the ignorance that is willingly and cheerfully fostered.

Again, do you think that when you advise your patient to go to a dispensary or hospital for free treatment for a form of disease you do not feel able to treat, either through inability or lack of appliances, that he or she will be likely to return to you when there is a trouble that you can easily and readily adjust and treat successfully? Do you think your patient will return to you with an office fee of fifty cents, or one dollar, or possibly more, when they can obtain the same at a hospital or dispensary for nothing? Surely it requires no syllogistic reasoning on my part to convince you that the lay public learns the lesson of obtaining something for nothing all too easily and only requires one lesson and that not of any lengthy duration. So you will find your practice drifting to that class that must call you to see them because they cannot leave their homes and you think yourself fortunate in getting those and waiting their pleasure until they see fit to pay you dribble by dribble and the collector brings news of repeated failures. You complain about business but sleep on in security that every man must keep every other one from making a living and sooner or later our hospitals and free dispensaries will widen their stakes and stretch their lines until every department and phase of human ailment and condition of man will be included. Hospitals do good, but the harm they do is greater and increasing too. The man that does not see the increase is the man who has his eyes shut to the light and the truth. The harm is not less than the good, but vice versa, the harm is by far greater than the good done. Look at the rivalry existing among our hospitals, look at the buildings, look at the appointments, and yet it is all for the poor. Further, look at the reports

of our hospitals. Do any of them show a decrease in the number of cases treated? Do any of them stand still? Nay, they show an increase, and a decided increase, and point with pride and disseminate literature in all directions, to the larger reports of this year over last year. What does this show? Does it show that the poor are increasing so rapidly? Nay, it shows that paupers are increasing. "Spongery" are on the advance ready to absorb and not return unless squeezed. Do you hear of hospitals closing doors? No, but you hear of hospitals opening and springing up in every community and the better nature of men and women everywhere is appealed to that they support this and that grand and noble institution (in pauperizing the community).

This trouble pertains not alone to the medical profession; patients are not the only ones sent to our hospitals, but parishioners are sent as well by pastors and ministers who should know better, so easy to say go to such and such a hospital and you can obtain the "best treatment free;" a great trio of words, best treatment free; it both flatters and degrades, flatters the man who dispenses the treatment and degrades the man, woman or child who receives. My friends, do you think it is less a crime to steal one's clothes than it is to steal treatment when able to pay for it? Do you think that lessons in honesty bear only to the taking of the material and the tangible? We are taught that he that looketh on a woman to lust hath already committed adultery. Again we are taught that he who thinketh murder is a murderer, yet the civil law does not hold a man guilty for thoughts, but the moral and Divine law does. You believe that—well, does not a man steal when he goes to a dispensary for free treatment when he is able to pay for it? Are you not an abettor, an accomplice, when you inculcate such ideas and advise him to do such? Do I present facts or do I not? I fail to find a single instance in Holy Writ where Christ ever helped a man or woman without first an effort on their part. In other words true charity consists in helping others to

help themselves, and not in doing something for others with no effort on their part. I maintain that the present system of charitable hospitals and free dispensaries is derogatory and wrong. Can I do any good by presenting these facts? Possibly not, but as man is a free agent he can therefore accept or reject what is presented to him. I feel it my duty to present facts as I see them; if I am wrong the fault is mine, not yours; if I am right and you know that I am right and still go on unheeded the fault is yours and not mine.

The subject is an all-important one; it has bearings not only upon men that work in hospitals, not only upon medical men generally, but upon all ramifications of society, upon all the different callings of life; it is no longer a question indigenous to the medical profession, but has risen to the higher plane of a social question. The medical profession, though, is largely responsible for the primitive lessons it has taught and for the iniquitous practice as it is now fostered, for without the aid of the medical profession it could not exist. Why the profession cannot stand as a unit for its own best interests is a lesson we should learn from the wage earner and the workingman. To me this question is equally as important as whether milk should be Pasteurized or sterilized; whether the comma bacillus is round or long; whether streptococci are found in pus or not; whether the cold bath treatment of typhoid is right or not; and so on, a host of questions good in themselves. Men may be lethargic from many causes. Some may have a sufficiency to keep themselves or even their families without any effort on their part but fortunately for man activity is his chief component and the majority need to keep active to keep happy and supply the needs of body, mind and soul.

Thirdly, this class is a very large one and is directly dependent and entirely due to the existence of the first and second above referred to. The first and second class are directly responsible for the existence of this third. I refer to the large numbers that come of their own free will either from previous ex-

periences or from experiences of their friends or relatives. This class may be subdivided into four classes.

The first of these classes are those who are really poor. Of this class I only have commendation to say; they are generally grateful for what you do for them, pay heed to your questions and really make the only good impressions so far as human nature is concerned. I make bold to say that far more evil is done than good, for evil travels on a faster train than does good, the evil takes wings, while good travels in the old-fashioned way by stage coach, so to speak. Let me illustrate my meaning. When a deserving case presents itself, receives treatment in some cases, in many cases relief is obtained and sometimes nothing can be done; well so far as the good done to that patient is concerned it remains with him or her but travels no further; but how about the case of a person that applies for admittance and treatment to our dispensaries that are able to pay? They obtain admittance very easily and receive treatment gratuitously, go out from the dispensary with a feeling of having beaten the doctors and with a conscience dwarfed and warped. Does this person keep his knowledge to himself? Do you think that he will not immediately tell all his friends that at such and such an institution you can be treated free? What is the use of your paying one dollar, even twenty-five or thirty cents, for medicine, when such and such an institution will give you advice, medicine and treatment free? Yet the city gives appropriations to help pauperize people and then complains of the almshouses and poorhouses being overcrowded. Do I state other than facts? Are they recognized? I say yes, by a large majority, but that self-same majority sleep on in a sleep like unto the sleep of a man benumbed and freezing, only to awake in death. So with the majority of our medical men and intelligent citizens; they will awake when it is too late. The question is not purely and only a question for medical men, but for all who are interested at all in questions of political economy and in society generally.

Secondly, I would call your attention to those who can and will not pay and avoid payment by simply lying about themselves when questioned. Many come to our dispensaries dressed well and with every appearance of well-to-do persons. Anyone, a close observer of humanity, can see by the sidelong glances, the roving tendency of the eyes, the shifting of the bodies from one place to another, and such like. I say any close observer can see this class every day in our city dispensaries rubbing and hobnobbing with denizens of allies and filthy tenements to save from fifty cents to a dollar or two, undergoing mental torture for a paltry sum and depriving honest men of a deserving living. When such an one is questioned about their ability to pay, answers come that can be characterized as nothing short of lies—falsehoods do not express it—for they are premeditated lies pure and simple. Others of this same social class will say when questioned whether they are able to pay, they will say "yes, I am able to pay." "Well, why do you come to a free dispensary?" "Because I do not propose to pay and will not pay." This is not a theoretical class emanating from the inmost recesses of the writer's brain, but are a bona fide class, as anyone connected with dispensaries can verify. I remember one instance of a woman who had paid her taxes bringing her tax bills with her and thought because she had paid taxes to the city she was entitled to free treatment at charity dispensaries. Again people are surprised that medical men serve at dispensaries without financial remuneration and are invariably surprised when informed that doctors give their services free to the various charitable institutions, thinking that the doctors are there to serve them, looking upon dispensaries as supplied by the State and city for any who might apply for treatment. Why not turn them away? I hear someone say, just turn one away and see what a row they will raise; they come with their minds made up that treatment they must receive, because so-and-so, who is better off financially than they, received treatment free and they are going to re-

ceive it too. Nay, they should never gain admittance; should never be entered upon the books of the dispensary. The trouble is at the door of the dispensary. Authorities of dispensaries usually have full and plenty and depend not upon the public for a living, having only the care of keeping a check book stub straight and live in blissful ignorance, soothing their consciences with the salve of magnanimous charity. Ah, what a multitude of sins doth charity cover beneath its ample folds. Dispensaries are increasing, the crowds are increasing, and the poor is increasing in numbers because it is easier to obtain something for nothing than to obtain something by an effort. Some one is helping many others in every dispensary in our city and other cities on the downward path to pauperism every day at the rate of hundreds for each circuit of the earth about the sun.

People could not be treated unless some one treated them and a dispensary could not be conducted unless some one or more in authority supported it. If it was good done to humanity and wrong done those that worked in them why the case would not be so bad, but it is wrong done to those that receive and wrong done to those that give. The receiver and the giver are not blessed by any means; rather are they in a measure stunted in the vital essentials of moral growth. The *sine qua non* of the dispensary would indeed be reached were the doctor and the patient both benefited. What a different aspect would be placed upon a dispensary life were only deserving patients treated. And yet that is the avowed purpose of its existence, the mesoblast of its embryonic existence, but with the addition of the epiblastic and hypoblastic layers of its year's growth, the functions so altered as to be as far removed from the original institution as hair and teeth are removed from one another, and yet both had a common origin. Yea, our dispensaries say, one and all, that they exist and flourish alone for the alleviation of suffering humanity among the poor. It is only the irony of words, the perversion of fundamental principles and

the alteration of cardinal, moral and well-known economic ethical laws.

The third class is by far the worst of the lot from every standpoint, as I will show later. The class I refer to is the class of people who honestly do not know just where to go, they have no particular choice, the dispensary in their neighborhood is well known, has done many wonderful cures, many marvelous operations and has a wide reputation. This class of people honestly and conscientiously come to the doors of dispensaries for treatment; they may come from another city, pass other institutions of a charitable character, pay railroad fare and other expenses incident to travel to reach Baltimore, we will say, they come expecting to pay and the hospital doors seem so hospitable, so very inviting that they say this is good; they enter their names, are entered without other question than name, age and address, treatment is dispensed with liberal hand, though rather a rapid hand at times, and the patient never once asked for pay of any kind; or if asked it is left entirely to his or her generosity to fix the amount of value received in services rendered. When a patient asks "How much, doctor?" he gasps out, "Put what you can in the charity box," and as the patient turns away, our hearing catches the sound of a dime or quarter. So we gain an insight to the charity box and we find it very much like the church plate when passed on Sundays, full of pennies and coins of small denominations. I believe this class to be by far the most deplorable, because first lessons are by the dispensaries taught this class who might by judicious treatment be made better citizens, be helped to help themselves than to be helped to a condition of pauperism and communism. These lessons are not taught alone to adults; children form a very large part of the list of applicants for charity.

There is a fourth class of patients that come to hospitals that may be well to mention at any rate. This class is of such a character that doctors connected with dispensaries easily remember them because they are like oases in the desert, few in number and very far between.

The class I refer to are those that come to us and say, "Doctor, I did not know just where to go and do not like the looks of the dispensary and feel certain that you cannot treat me properly where so many are to be treated ; where is your office ? I would like to call and see you privately." Put that one down as an extremely honest man (or woman,

as the case may be) or a great rascal. I have seen patients on dispensary benches whose cheeks were blushed with shame at being seen in a dispensary and would say that they had never been in a free dispensary before and were ashamed to be seen there, but they had been sent there by their family physician for treatment.

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## MEDICAL EDUCATION OF TODAY.

*By Charles E. Simon, M. D.,  
Baltimore.*

HAS the American Medical College Association achieved the desired end by raising the course of study to four years?

The last ten years have witnessed many important changes that have been brought about in the education of the medical student. Only six years ago, a training extending over not more than twelve months was deemed sufficient to start the young practitioner upon his career in the larger number of our American medical colleges. A previous knowledge of reading, writing and arithmetic was practically all that was required as a basis for the study of anatomy, chemistry, physiology, materia medica and therapeutics, medicine, surgery, gynecology, obstetrics, dermatology, otology, ophthalmology, pediatrics, laryngology, neurology and medical jurisprudence.

Under such circumstances one might imagine that ninety-nine young men out of one hundred would have recoiled with horror at such an undertaking, and would have found general laboring work a task at which they would be more likely to succeed. Such, however, was not the case, for the would-be worshiper at the shrine of Aesculapius found that with a fair set of notes, and a knowledge of how the professor liked to have his questions answered, the sheepskin could be obtained without very much difficulty.

Having witnessed the removal of diseased ovaries through an incision of from two to three inches in length, the operation of hair-lip, for appendicitis,

etc., from his seat, at least six feet distant from the wall of assistants surrounding the operating table, he is now prepared to take charge of a colony of miners from a surgical point of view. After having safely delivered an alcoholic fetus through the relaxed outlet of the manikin, and after having witnessed an uncomplicated delivery at the Maternite, he wildly plunges into midwifery.

He has been informed that a systolic murmur of maximum intensity at the apex, which is propagated to the axilla and heard at the angle of the scapula, is a most important physical sign of mitral regurgitation ; he is then well prepared to take up the diseases of the chest as a specialty. The microscope he has seen in the show-windows of opticians. He does not understand its use exactly, but that is of no moment ; microscopy was not taught at school, and can hence not be a very important science. Chemistry he has passed, and he remembers distinctly that sodium belongs to the class of metals. He has heard of bacteriological, pathological, chemical and physical laboratories, but has not as yet had an opportunity of seeing what is actually accomplished in such places. His teachers he remembers with gratitude, and recognizes that for the many deficiencies in his knowledge they were not directly to blame. At the expense of his patient he gathers experience. Experience shows him the knowledge he lacks and as a wiser man he decides upon certain post-graduate studies. Three months thus spent show

him the advisability of returning to such studies as often as possible.

It is true a few fortunate students have had the opportunity of acting as internes in the hospitals, but the number is small.

In the course of time the medical profession awakens to the conviction that the public actually has a right to demand more knowledge, and above all, some practical knowledge from the newly fledged M. D., and after due deliberations and consultations, a course of study extending over three years, each of six months' duration, is decided upon by the American Medical College Association. At the present time, four years are even required by the members of the same Association, which it may be stated was called into existence chiefly through the untiring efforts of Dr. Eugene F. Cordell of Baltimore.

In his interesting article on the origin, development and present status of this Association (*MARYLAND MEDICAL JOURNAL*, January 11, 1896) Dr. Cordell expresses the belief that in former years it was possible for a student to matriculate and even graduate without knowing how to read and write. In this belief, Dr. Cordell does not stand alone, and what is more, it is the writer's honest belief that even at the present time a large number of students are permitted to matriculate who, to say the least, do not know how to write correctly, notwithstanding the fact that they enter schools which are members of the Association.

Be this as it may, the question is now, what has been gained by raising the course of study leading to the degree of M. D. from two to four years, and was such a step actually justifiable? The latter question may be answered in the affirmative upon general principles; in practice, however, the answer must be "No," in the case of the majority of our medical colleges. The reason for this answer is not difficult to see. Unfortunately, but perhaps also fortunately, a large number of our medical colleges are financially incapable of providing for their students those opportunities for thorough study which could be de-

manded under the circumstances, and which alone would appear to render the adoption of a four years' course justifiable. As long as those teachers who are to guide the laboratory work of students are either not paid at all for their work and time, or receive a mere pittance, it cannot be expected from them that they attend to more than the most necessary work.

In other words, while a thorough course of laboratory work in chemistry, anatomy, histology, pathology and bacteriology is advertised, a thorough course actually does not exist, and cannot exist under the present circumstances. The students at best only receive a smattering knowledge of the subject.

Laboratory methods of diagnosis, moreover, are almost entirely neglected. Clinical laboratories either do not exist at all, or they are such as do not deserve the name. The knowledge which the student carries with him from college of urinary analysis is practically zero. To him albumen and casts in the urine mean Bright's disease, and sugar, diabetes. If he has learned to test intelligently for albumen and sugar at all, he has not learned how to interpret his results. The examination of the blood for malarial parasites, the differential study of the leucocytes, are unknown quantities. The examination of membranes for Löffler's bacillus, of the sputum for tubercle bacilli, of the feces for parasites or their ova, must be learned later on or not at all.

The student hears of the stomach tube, and even sees a stomach washed out; the examination of the gastric contents and the interpretation of the results reached, however, he is not taught, unless, indeed, the college is fortunate enough to include a gastro-enterologist in its faculty.

How many physicians actually possess a microscope, and how many of those who do have one employ it? How many physicians possess laboratory facilities, no matter how primitive, in connection with their "office?" The usual reply which is given to the question "Have you examined this or that man's

blood, sputum, gastric juice or urine" is: "Oh, I have no time for such things; that will do very well for scientific men, but we general practitioners are too busy to bother about that." The practice of medicine is a science and not a "business," and there can be no doubt that the busy practitioner, who has no time for accurate methods of diagnosis, will go to the wall, and the scientific physician will step to the front.

The public demand, and they have a right to do so, that practitioners in medicine give their patients the benefit of every new and valuable discovery in medicine. They wish to know the nature of their ailments and rely upon the honesty and knowledge of their attendants, that all diagnostic means known to medicine shall be brought to bear upon their case.

The public has come to realize that "diagnosis" and not "drugging" is

now the password of advanced medical science.

Who is responsible for the lack of interest and ignorance on the part of the medical practitioner in matters of accurate diagnosis, if not the medical colleges? As long as such institutions are in the hands of their faculties, without endowments, without material aid from the State to which they belong, there can be but little prospect of much improvement. Lengthening the course of study indefinitely will alone not produce the desired results. A medical college which depends for its existence upon the tuition fees received from its students should be abolished. The students at the present time are largely receiving less for their fees than they are entitled to, and it is for them to boycott a college which only nominally belongs to the American Medical College Association and which in reality is only an empty shell.

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**ABSCESS OF THE OVARY.**—Tait says that abscess of the ovary is a rare condition, therefore the case reported by Dr. Robert T. Wilson of Baltimore before the Gynecological and Obstetrical Society of Baltimore, and noted in the *American Journal of Obstetrics*, is of especial interest. She was a multipara. Soon after the birth of her second child she was startled and jumped out of bed with little clothing on, exposed herself and had a chill.

Dr. Wilson found chills and fever, high temperature and other signs which made him think an abdominal operation necessary. He found a tumor as large as an infant's head, which proved to be an enormous abscess of the ovary which broke in the abdominal cavity. Dr. Wilson removed the ovary, washed out the abdominal cavity, used drainage and the woman recovered. The case is interesting because a true abscess of the ovary is rare, because Monsel's solution was used and because the cavity was washed out instead of being sponged out. The use of the drainage tube is important.

**UREA IN URINARY CALCULI.**—Klemperer (*American Medico-Surgical Bulletin*) draws attention to the solvent powers of pure urea on uric acid. In various cases of nephrolithiasis he has employed urea in 1:200 to 20:200 solutions, and has observed that in a large number of the patients, the remedy not only acted as a strong uric acid solvent, but that it possessed also diuretic properties. He considers pure urea a physiological diuretic much superior to piperazine or lysidin.

He usually prescribes it as follows:

Pure Urea . . . 10 gme. (154 grn.)  
Distilled Water 200 gme. (6½ fl. oz.)  
Tablespoonful every hour.

The solution may be gradually increased to 15:200 and 20:200. The latter solution is taken once daily for from two to three weeks. Even these large doses of urea did not in the least disturb the appetite or digestion.

The taste of the solution is not a pleasant one, but it may readily be removed by taking a drink of milk afterwards.

## Society Reports.

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### COLLEGE OF PHYSICIANS OF PHILADELPHIA.

#### SECTION ON OPHTHALMOLOGY.

MEETING HELD DECEMBER 17, 1895.

A STATED meeting of the Section on Ophthalmology was held in the Lower Hall, College of Physicians, on December 17, 1895, Dr. Wm. F. Norris, Chairman, presiding. Present : Drs. Friebis, Hansell, Harlan, Norris, Oliver, Shaffner, Thomas, Thomson, and Zentmayer, Fellows of the College, and Drs. Chance, Krauss, Perrine, Shoemaker, Sulzer, A. G. Thomson, and Ziegler as guests.

*Dr. George C. Harlan* made some remarks upon the so-called "Corneal Reflex" seen in ophthalmoscopic examination by the direct method.

*Dr. William Thomson* stated that he was very much interested in the paper, having made some experiments with both convex and concave lenses upon distant points of light and had been able to obtain a series of both interesting and valuable entoptic phenomena by the use of artificial eyes or any small object with a small radius of curvature which was about equal to that of the human eye. He had been able to discover slight corneal haze and lenticular opacities. He considered that the method was of clinical value in determinations regarding the transparency of the various media of the eye.

*Dr. Howard F. Hansell* spoke of the entoptic appearance of vitreous opacities in uncorrected myopia; these totally disappearing when proper corrections are placed before the eyes.

*Dr. Charles Shaffner* considered that some entoptic phenomena seen in myopia might be dependent upon disturbances situated in the intra-ocular circulation producing a low grade of engorgement and inflammatory reaction, and that vitreous opacities so caused disappear only gradually or not at all.

*Dr. Charles A. Oliver* read a paper upon the "Therapeutic Value of Hydrobromate of Scopolamine in Plastic Iritis," in which he showed that for quick

and active measures, which are so necessary in the incipient cases of this form of disease and during the early stages of inflammatory reaction, the drug is very important; but where prolonged use is necessary, as in many cases of the chronic form of the disease with subacute exacerbations, the good effect does not seem to be so lasting. For these reasons, he has learned empirically to depend upon the drug where prompt action is necessary, but where more permanent effects are desired, he alternates its use with that of atropine.

This was discussed by Drs. Hansell, Harlan, Thomas and Shaffner, who inquired as to its relative value as compared with other mydriatics.

*Dr. Friebis* spoke of the general effects of several of the stronger mydriatics. To these queries—

*Dr. Oliver* replied that in the dosages in which he had employed the drug, he had never seen any symptoms of poisoning, although in several of the cases in which he had used it freely, there were, at times, giddiness, incoordination of movement and drowsiness. In regard to the question of intra-ocular tension, he intended to perform a series of experimental researches and to make a relative study of the other mydriatics with which the drug has been usually thought to be associated, or, in fact, considered identical.

*Dr. Charles Hermon Thomas* exhibited the latest and most improved form of Stevens' Tropometer, by which a magnified view of the cornea appears against an illuminated scale, thus allowing an observer the exact register in degrees of arc measurement of the movement of the cornea across the scale from any definite point, thereby giving an index, as it were, of the length of excursion that is performed by any series of extra-ocular muscles in order to obtain the extremes of motion in either the horizontal or vertical meridians. He considered the instrument of value in the estimation not only of the manifest and the latent types of heterophoria and heterotropia, but of value in the recognition of paretic conditions of the muscle groupings.

*Dr. Thomson* related a brief history of a case in which the instrument evolved an absolute distinction between the directions of faulty action in a vertical strabismus which could not be determined in any other known way.

*Dr. Thomas* gave the details of a similar case, and stated that he had received a letter from Dr. George T. Stevens in regard to the liability of error in the reading of the measurements that is apt to arise unless the eye is absolutely primarily fixed upon the point of fixation; this, however, he had in a great measure provided against by change in instrumentation, whereby the head of the patient is kept almost motionless by clenching a removable wooden bit between the teeth.

*Dr. William Zentmayer* exhibited a case and showed a drawing of a cilio-retinal artery in which the two main branches extended into the macular region.

### Correspondence.

#### THE HEALTH COMMISSIONER.

BALTIMORE, March 16, 1896.

Editor MARYLAND MEDICAL JOURNAL:

Dear Sir:—The recent action of the City Council in rejecting the nomination of Dr. McShane as Health Commissioner of the city is to be deeply regretted, as it shows that party politics and not merit shall control one of the most important offices of the city. With such curious instincts as the present City Council appears to be imbued, it would not be surprising if the physicians of Baltimore were to wake up some morning and be startled by the news that a Republican, I. Freeman Rasin, not even an M. D., had been appointed by our most illustrious body of City Councilmen as guardian of the public health. It is usually stated that conservatism is one of the principal characteristics of the people of Baltimore. "General indifference," perhaps, would be a more appropriate word. So much at least is true that it would be difficult to find a body of physicians more indif-

ferent to questions appertaining to the health of the city than the medical profession of Baltimore.

It is perfectly manifest that Mayor Hooper is willing to do the best in his power for the people who have elected him to his present position. There can also be no doubt that were the physicians of Baltimore to assemble and to select one of their number, who should be pre-eminently fitted to take charge of so important an office as that of Health Commissioner, Mayor Hooper would certainly be willing to act upon the advice of a body of men who are in a position to judge of the necessary qualifications of an applicant for this position. Why not let vacancies occurring in the various medical colleges of Baltimore be filled by the City Council as well as the position of Health Commissioner? As it is, an applicant for office is endorsed by a number of excellent citizens, by certain physicians and ministers, another by others, a third by still others, and four by others and so on. Six physicians in the city have signified their willingness to take charge of the Health Commissioner's office.

Should Mayor Hooper decide to yield and not to return Dr. McShane's name to the City Council, it is clear that our next Health Commissioner will be he who in the eyes of the City Council is the "best" Republican. It appears insane that a body of laymen, not one of whom probably has an idea of what a Health Commissioner should know and be, should be placed in a position to accept or reject the Mayor's nomination, as it may suit their political tastes. Dr. McShane has done his full duty in the past. If he did not succeed in many things, the Mayor, the City Council, and especially the medical profession, are to blame for not giving him their honest support. Much more good would be accomplished were the different medical societies of the city to consider questions of public hygiene in their meetings than to pass away time in discussions which usually lead to nothing. If Dr. McShane enjoys the confidence of the medical profession of Baltimore, then let steps be taken to retain him in office.

If not, let the Medical and Chirurgical Faculty call a meeting to select one man for the office from their number. If, however, Dr. McShane should be deposed simply because he is a Democrat and is acquainted at present with various members of the old ring, then let every honest physician blush with shame over what would be a despicable action on the part of his brethren.

Very truly,

CHARLES E. SIMON, M. D.  
1302 Madison Avenue.

### Medical Progress.

**PUS IN THE PELVIS.**—Dr. Thomas A. Ashby calls attention, in the *American Journal of Obstetrics*, to the danger of delay in dealing with pus in the pelvis. He related several cases showing the importance and necessity for removing pus sacs and says in conclusion :

The handwriting is on the wall, and all one has to do is to interpret it with care and intelligence. I by no means wish to convey the idea that the chronic pus sac is responsible for all or even for a large number of cases presenting symptoms of anemia, malaria, or of organic changes in the heart, kidneys, or other organs. What I do wish to insist upon is a more careful investigation of the pelvic organs in woman and a proper interpretation of the etiology of her symptoms. If the pus sac is not present no harm results from the investigation, but if present its removal is clearly indicated. The sooner we recognize the danger of pus and remove this danger the better will it be for the unfortunate possessor of such a condition ; for, delay as long as we may, sooner or later in the vast majority of these cases immediate or remote symptoms will arise to chastise us for our neglect.

I shall not consider here the methods now employed for dealing with pus in the pelvis. The surgeon may select either the abdominal or vaginal route for the removal of the pus sac, at will. He has eminent authority for the employment of either of these routes. The one important fact is, remove the pus

sac by the best ascertainable route present in the individual case. Operate early, before complications arise, and be as thorough as possible in removing the sac wall and infected area.

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**RESTRICTION OF TUBERCULOSIS.**—In the *Medical News*, Dr. John L. Heffron asks if the State shall undertake to restrict the spread of tuberculosis, which he answers as follows :

1. Tuberculosis is an infectious and curable disease, capable of restriction.
2. That the State should compel the registration of every case of tubercular disease.
3. That circulars of information as to the nature, communicability and sanitary care of all tubercular disease should be sent to those afflicted with the disease and to those attending them.
4. That instruction as to the nature of contagious and infectious diseases and the practical methods for their control should be given to all senior pupils in public grammar schools.
5. That all owners and trustees of places of public entertainment, including churches and schools, and all public carriers should be required to prevent contamination of their halls and conveyances, and to disinfect them when contaminated.
6. That the hopelessly ignorant, wilfully careless and vicious afflicted with tuberculosis should be isolated in special hospitals provided by the State.

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**POTASSIUM NITRATE IN THE TREATMENT OF BURNS.**—In an article published in the *Revue médicale* and quoted in the *New York Medical Journal*, the writer says that Dr. Poggi, in a recent thesis on this subject, gives an account of a treatment that has given excellent results in all kinds of burns of whatever degree. It consists in the employment of potassium nitrate, which is administered in baths or in applications of compresses that have been wet with a saturated solution of this salt, or in lotions that contain the nitrate.

According to M. Poggi, the nitrate acts especially as a refrigerant. As it becomes dissolved in the water it pro-

duces a notable lowering of the temperature of the liquid from 5° to 9° F. If a burned hand or foot is plunged into a basin of water to which a few spoonfuls of the nitrate has been added, the pain ceases rapidly; if the water becomes slightly heated, the pain returns, but it is allayed as soon as a fresh quantity of the salt is added. This bath, which is prolonged from two to three hours, may bring about the definitive disappearance of the pain and even prevent the production of blisters. The application of the compresses also exercises the same influence. By this means the pain is allayed and cicatrization takes place without delay.

Another remedy in the treatment of burns is calcined magnesia, which, says the writer, has been employed by M. Vergely, who obtained favorable results with it in burns of the first and second degree. The affected parts are covered with a thick layer of a paste which is prepared by mixing the calcined magnesia with a certain quantity of water. This paste is allowed to dry on the skin and when it becomes detached and falls off it is replaced by a fresh application. Very soon after the paste is applied the pain ceases, and under the protective covering formed by the magnesia the wounds recover without leaving the cutaneous pigmentation which is so often observed to follow burns that have been allowed to remain exposed to the air.

\* \*

**MEDICINE AND POLITICS.**—Practitioners of medicine, like other people, have the unquestionable right to occupy themselves with politics and to take sides according to their convictions. We will even go further, says the *Lancet*, and say it is the bounden duty of all citizens, no matter what their professions or occupations may be, to assume a fair share in the conduct of public affairs and do their best to promote the welfare of the State whereof they are members. It is only as private individuals, however, that medical men can claim the privilege of partisanship. In everything that concerns purely professional and scientific matters they have no nationality. A medical practitioner, more

perhaps than anyone else save a minister of religion, has the right to say with Terence, *Homo sum; humani nihil a me alienum puto*. Unfortunately, this noble sentiment is far from being universally acted up to, especially on the Continent, where political feelings are far too often allowed to gain the upper hand. Some months ago a very flagrant exhibition of international intolerance occurred at Antwerp, and we are sorry to learn that the solution of continuity which then took place has not yet been healed or even bridged over. A German physician, having established himself professionally in that ancient city, sought and obtained admission to the local medical society. But no sooner was his membership an accomplished fact than a strenuous, though happily unsuccessful, attempt was made to cancel the election. Upon this a number of malcontents seceded in order to start a society of their own; and in spite of the utmost efforts of the leaders of the profession in Antwerp to bring about a more desirable condition of things the regrettable schism still continues.

\* \*

**COUGH.**—In an article on cough, in *Medicine*, Dr. Robert H. Babcock of Chicago speaks of the disproportion in the severity of the cough to the lesion. He finds codeine the most useful drug for this symptom. In spasmodic cough he used a combination of bromoform, tincture of gelsemium and syrup of lactucarium. In other cases he has used bromoform, codeine phosphate, compound syrup of squill, syrup of lactucarium and mucilage of acacia.

\* \*

**OPERATION IN HEPATIC ABSCESS.**—M. Fontan (*International Medical Journal*) has attended forty cases of abscess of the liver following dysentery contracted in tropical countries. He has adopted as rules for operating: first, a free incision, at least eight or ten centimeters long; second, the final resection of one or more costal cartilages to expose the abscess freely; third, the separate suturing of the peritoneum and of the pleura; fourth, the complete curetttement of the cavity of the abscess.

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BALTIMORE, MARCH 21, 1896.

AT this season of the year, when the faithful are in sackcloth and ashes, the question is often asked, "What effect has the observance of Lent upon the health?"

*Lenten Penance and Winter Sunbeams.*

It is not sure that one can say much that is new in attempting to answer the question, since the hygienic relation of the Lenten Fast has been discussed by scientific men having no other determination than that of telling the truth, although, with the fallibility common to human judgment, it is denied on one hand that there is any merit in fasting, while, on the other, it is maintained that the disciplinary prohibition of Lent is a law of conservation that is happy in its influence.

It is well known that the meteorological conditions of spring bring about a general awakening of entire organic life and that this very remembrance may become a source of danger and derangement to health, particularly among persons endowed with strong

imagination and in need of moral self-restraint.

At the very vestibule of this critical season the obligatory abstinence exacted by the Lenten observance has a salutary effect in keeping down the concupiscent appetite of the body and thereby favoring health in the way of prevention rather than cure.

In certain susceptible persons fasting may bring about an abnormal nervous state or an exaltation of the faculties which is supposed to bring the devotee into closer relation with the Infinite; but this touching upon a question beyond the province of medicine and one that admits of different connotation according as the soul is Catholic or the stomach Protestant, it is only necessary to say that the Lenten fast can do no harm, unless it be among persons in whom the exigencies of hard work call for a strong diet, or among such cases as may be interdicted by a physician.

The system of self-denial that the Lenten observance imposes upon us, aside from being a physical benefit, teaches humility and furthermore promotes the exercise of voluntary privations, which all will admit is the most difficult and the most productive of virtues.

The marrow-piercing winds that always accompany this season cause many people to hie themselves to a more restful clime in search of winter sunbeams and the much-needed rest that excessive gaiety or bad health has made imperative. Barring seasickness, it is anything but a Lenten penance to take a run down the Antilles, where an invalid, a convalescent or a pleasure seeker, after quitting one of the eastern ports, escapes the cold wind of the coast and arrives in four or five days—to use the words of Darwin—at "a great wild, untidy, luxuriant hot-house," like Jamaica, or amid such tropic loveliness as one sees at St. Kitts or Montserrat, two of the loveliest and most beautiful islands in the world.

An account of the medical topography of the West Indies by a Fellow of the Royal Geographical Society, Dr. Irving C. Rosse of Washington, D. C., is to be found in "The Reference Hand-Book of the Medical Sciences." Dr. Rosse's experience as a traveler and medical writer qualifies him to speak advisedly on this subject. Therefore all persons contemplating a trip to the West Indies, either for health or pleasure, and who wish

to be informed, are advised to read this instructive paper.

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IN these days when new methods and new therapeutic agents are brought forward so often with little exper-

*Expectorants.* mental backing, it is interesting to read of clinical tests of well-known remedies.

Dr. James K. Crook, in the *Medical Record*, has been inquiring into the relative value of expectorants and cough remedies and he considers such substances as aconite, ammonium bromide, ammonium carbonate, ammonium chloride, antimony, apomorphine, chloroform codeine, creosote, glycerine, *glycyrrhiza*, Hoffman's anodyne, hydrocyanic acid, ipecac, opiates, phenacetine, potassium bromide, potassium iodide, squill, sodium chloride, terebene, terpin hydrate, tolu and wild cherry.

The object of these inquiries was to test, individually and separately and without reference to the researches of others, a number of the principal therapeutic agents in use at the present day for the relief of cough. He finds ammonium carbonate not half so useful as ammonium muriate, and he uses the latter in small doses at first, beginning with two or three grains and going on to ten to fifteen.

Codeine was very effective in irritative cough but it was constipating when used in amounts of one-sixth of a grain. This seems rather astounding when the dose is usually put down as from one-half to two grains and the constipating and other unpleasant effects are not so marked as in morphia. Hydrocyanic acid is classed as a mild sedative, when in nervous coughs it certainly is of great benefit, but it is dangerous and must be used with extreme caution. Ipecac is better than squill and both are to be preferred to wild cherry bark. Terebene is faintly praised, while terpin hydrate is considered as almost worthless.

The best results are, of course, as he says, obtained by a scientific combination of all these remedies, but the skeptic may feel doubtful of benefit after so many are put down as possessing so little virtue. In conclusion the author presents a number of combinations which have found favor in his eyes and which he recommends to his colleagues.

While articles of this kind possess little originality, still they have their value and to the man who pins all his faith on drugs such work is of inestimable merit.

IF the physician does a great deal of work with no material returns and little gratitude,

he has only himself to thank

*Dispensary Abuse.* for it, as Dr. Mansfield shows in this issue. The number of the deserving poor is certainly not increasing and yet there are few hospitals and dispensaries but what show an increase of work each year.

Naturally the average physician cannot compete with an endowed and subsidized institution and when the best treatment is given gratis with the prescription thrown in and no questions as to ability to pay asked, it is very natural that many persons should seek to economize in that way.

The true way to help persons is to show them how to help themselves, and physicians could assist the various charity organizations in their truly philanthropic work by preserving in their dispensary work a list of all persons who may be suspected of seeking free medical aid when they do not deserve it.

The true physician rarely refuses to give his aid with no remuneration, but he must live, and if some few men attain a great reputation and acquire wealth it should not make the public believe that a physician's life is a royal road to wealth. Between the dispensary and hospital abuse in this country and the abuse of the club practice in England many physicians are deprived of cases which could and would pay and many persons are taught to lose their self-respect by accepting alms when they could pay for these services.

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IF the almanacs tell the truth, this is the first day of spring and with the advent of this balmy season come the *Spring and Medical* announcements of various Societies. local and general medical societies, which will hold

annual meetings within the next few months. The medical man loves his recreation and enjoys a good rest as much as anyone, and care has been taken of late that the place and time of meeting of these societies shall be as fitting as possible, so that members may combine business with pleasure and return to their work not only with new ideas, but refreshed and invigorated. The American Medical Association will hold its next meeting at Atlanta in May and there are prospects of an especially enjoyable session.

## Medical Items.

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We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending March 14, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....	1	
Pneumonia.....		30
Phthisis Pulmonalis.....		31
Measles.....	29	
Whooping Cough.....	3	3
Pseudo-membranous Croup and Diphtheria.	17	7
Mumps.....	4	
Scarlet fever.....	12	2
Varioloid.....		
Varicella.....	2	
Typhoid fever.....	1	

Oculists in New York are fighting the bill before the Legislature of that State to create lay ophthalmologists.

Dr. Hiram Corson, of the class of 1828, University of Pennsylvania, died at his home in Montgomery County, ninety-two years old.

Dr. Reverdy B. Stewart died at Warren, Pa., last week in the fifty-second year of his age. He was graduated from the University of Maryland in 1865.

The death is announced of Dr. T. Laennec, formerly Director of the Nantes School of Medicine and nephew of the great Laennec. Dr. T. Laennec graduated M. D. in 1856.

Dr. Augustus Riggs of Cooksville, Howard County, Maryland, died at his home last week after a short illness from pneumonia. Dr. Riggs was graduated from the University of Maryland in 1874.

Dr. F. A. Bowerman, of the City Hospital, and a graduate of the College of Physicians and Surgeons, has just obtained by competitive examination a position in one of the New York insane hospitals.

Dr. Robert B. Morison has recovered from his recent indisposition and is attending to his practice at his office, corner of St. Paul and Read Streets. He has never had the intention of giving up his practice, as was falsely reported.

Dr. George R. Graham of 725 Columbia Avenue is the City Council's candidate for Health Commissioner of Baltimore. Dr. Graham is a graduate of the University of Maryland and is a member of the State Faculty and the Clinical Society.

Dr. Winthrop Sargent, a widely known resident of Boston, died at his home last Monday, after a long illness, aged seventy years. Dr. Sargent was one of the best-known army surgeons during the Civil War and for many years he was engaged in the practice of his profession in Philadelphia.

The Anne Arundel County Medical Association held an informal meeting last week and appointed the following committee to urge upon the Legislature the passage of a bill to pay physicians when they are called upon to render services to indigent sick people: Drs. George Wells, Harry B. Gantt, and Charles E. Henkle.

The Trunk Line Association has authorized rate fare of one and one-third to Atlanta on occasion of the American Medical Association and we have assurances from the Southern Railway that the Southern States Passenger Association, of which that road is a member, will make a similar reduction in the South.

As the City Hall is so crowded, and also on account of the danger from contagious diseases, the Health Department will shortly be removed from the City Hall to another building and space will also be provided for the chemical laboratory and any other laboratories which the Council may allow. The Bay View office will also be in this building.

Dr. Birnie, Chairman of the Ways and Means Committee, Annapolis, reported the following appropriations for the next two years, the amounts named being for each year: Hospital of the Woman's Medical College, \$1500; Lying-in Hospital, \$3000; Nursery and Child's Hospital, \$2500; Hebrew Hospital, \$2500; Home for Incurables, \$2000; Lying-in Hospital for Indigent Women, \$2000; Hospital for the Women of Maryland, \$2000; Maryland General Hospital, \$5000; the Baltimore City Hospital, \$5000; University of Maryland, \$5000; St. Agnes Hospital, \$2500; Home and Infirmary at Cumberland, \$5000; Baltimore University School of Medicine, \$1000.

## WASHINGTON NOTES.

Weekly Report from the Health Department. Weekly mortality (for week ending March 7). Apoplexy 4, bronchitis 6, congestion of lungs 4, consumption 13, convulsions 3, diphtheria 2, diseases of brain 6, diseases of heart 8, diseases of kidneys 10, malarial fevers 2, malignant growths 1, measles 5, pneumonia 20, typhoid fever 1, miscellaneous 23, grippe 4; total 112. There was a material decrease in the number of deaths which occurred in the District during the last week as compared with those which occurred during the week preceding. The mortality fell from 139 to 112, with a corresponding decrease in the death rate from 26.2 to 21.1, reaching a point 3.5 per thousand less than the death rate during the corresponding week of last year. Five deaths from measles indicate the continued prevalence of that disease. One death from typhoid fever and two from diphtheria. There were four fatal cases from grippe and two from diseases of the kidneys. Consumption and pneumonia maintained their recent high death rate, thirteen deaths having occurred from the former disease and twenty from the latter. Seven new cases of diphtheria are reported during the week and six houses were released from quarantine; at the close of the week seventeen premises were still placarded on account of this disease. Of scarlet fever, six new cases were reported and six houses were released from quarantine; seventeen houses remained placarded. Of the entire number of deaths, fourteen occurred in hospitals and seven were certified to by the coroner. One hundred and seven births were reported and forty-one marriages.

The House of Representatives has passed a bill directing the Commissioners to establish and maintain within the District a hospital for inebriates for the treatment and cure of persons suffering from excessive use of alcoholic liquors, opium and cocaine, which hospital shall be a public institution of the District and under the control of the Commissioners.

The South Washington Free Dispensary was organized December 26, 1895, and incorporated by the attending staff February 10, 1896. Over three hundred poor patients have been treated up to this time, about one-fourth of whom are able to pay a small price for

their medicines. The dispensary is located in a part of the city where there are many poor people and consequently has been a success from the start. The attending staff are as follows: Dr. James D. Morgan—Diseases of Throat and Chest and General Medicine; Dr. Charles L. Allen—Nervous Diseases and General Medicine; Dr. George Borrie—Surgery; Dr. Henry A. Robbins—Skin and Venereal Diseases; Dr. Henry D. Fry—Diseases of Women; Dr. D. K. Shute—Diseases of the Eye.

The Medical Society of the District of Columbia held its regular weekly meeting on Wednesday, March 11. Dr. Jos. Taber Johnson presented specimens of seven cases of hysterectomy. Dr. C. R. Dufour read a paper on "The Relations of General Disease to the Formation of Cataract." "Dr. C. W. Richardson reported a "Case of Foreign Body in the Esophagus."

## Book Reviews.

**PRINCIPLES OF SURGERY.** By N. Senn, M.D., Ph.D., LL.D., Professor of Practice of Surgery and Clinical Surgery in Rush Medical College, Chicago, etc. Second Edition. Thoroughly Revised. Illustrated with 178 Wood Engravings and Five Colored Plates. Royal Octavo, Pages xvi, 656. Extra Cloth, \$4.60 net; Sheep or Half-Russia, \$5.50 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

The first edition of Senn's *Principles of Surgery* was issued in 1890, and at once was recognized as an authority upon those subjects of which it treated. A second edition is now published, which is an improvement upon the first in many particulars. The present volume has been thoroughly revised and brought up to date, and it has increased in bulk to the extent of 45 pages, and more than 50 new illustrations have been added. A number of colored plates showing the microscopical appearance of various stained micro-organisms also adds to the value of the present as compared with the previous edition.

It has always seemed to the reviewer that the title *Principles of Surgery* as applied to this book is somewhat misleading and perhaps rather too ambitious. As far as it goes it treats of the principles of surgery, but there is a vast deal which legitimately belongs to the principles of surgery that one will seek for in vain in this work. The whole subject of tumors has been omitted, and as an-

nounced by Dr. Senn in his preface, has been issued as a separate volume on the "Pathology and Surgical Treatment of Tumors." Whilst it would have been unwise to have taken up more than half of the book with a consideration of tumors, nevertheless a work on the principles of surgery ought to give a fair résumé of this important class of surgical diseases. The work on tumors referred to above contains 53 more pages than the present volume.

Again, a disease as far-reaching as syphilis is certainly deserving of some notice in a work of this character. The subject of rachitis is also not mentioned, though it is one of the most potent causes of deformities. Senn's book, then, does not treat of the principles of surgery *in extenso*, but of reparative processes and of those diseases which are due to the invasion of the tissues with bacteria, in short, of repair and infection. On these subjects the work is authoritative, being up to date both in regard to the pathology, clinical history and treatment of these important affections.

It is the only book written in the English language which is devoted exclusively to these subjects.

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#### REPRINTS, ETC., RECEIVED.

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Adams' Nervine Asylum, 1895.

Insured Lives are Affected by Gout.

The Surgery of the Ureters and Kidneys.  
By Hunter Robb, M. D.

Rational Treatment of Pertussis. By Francis T. B. Fesh, M. D. Reprint from the *Journal*.

Urethroscopy in Chronic Urethritis. By Ferd. C. Valentine, M. D. Reprint from the *Medical Record*.

Rhinological Dent's. By Edward J. Birmingham, A. M., M. D. Reprint from the *Texas Medical Journal*.

Some Salient Points in the Diagnosis, Pathology and treatment of Appendicitis. By John B. Deaver, M. D. Reprint from the *Medical News*.

Prevention and Treatment of Cholera. The Treatment of Typhoid Fever. By Elmer Lee, A. M., M. D., Ph.B. Reprint from the *Chicago Clinical Review*.

#### Current Editorial Comment.

##### THE BUSY DOCTOR.

*Medical Mirror.*

I OFTEN hear of the awfully busy doctor—he who is on the road from night until morning and from morning until night—too busy to study, and my sympathy goes out to him, but most of all to his victims, and I am more than ever disposed to agree with Goethe in the sentiment that "there is nothing more terrible than energetic ignorance."

##### THE MORALITY OF PHYSICIANS.

*The General Practitioner.*

IT is our private and public opinion and not influenced by being, as it were, inside the egg, either that medical students and medical men generally will average up pretty so-so with any class, society, clique or profession of men anywhere. An M. D. has no more effect, when attached to a man's name, in preventing him from being an ass, or a villain for that matter, than a D. D. As to the profession as a whole there is no class of men to which so much is trusted, where the trust is so seldom betrayed.

##### SYMMETRICAL DEVELOPMENT.

*Canada Medical Record.*

THOSE who take an interest in the the proper evolution of children into well-developed adults concede the necesity of well regulated and constant physical exercise. Good results only follow courses of training which bring equally into action all the muscles of the body, and in such a manner that both sides of our dual organization are equally exercised. It has only been the result of generation and centuries of habit, that in the majority of people the dexterity of the right hand supersedes that of the left, and education of these limbs equally from childhood up would doubtless, in a generation or two, lead to a condition in which the individual would be normally ambidexterous. It is not only necessary that both sides of the body should be equally exercised, but of the greatest importance that absolute symmetry in shape, size and proportion should be aimed at. Hence the necessity that all physical training should be regulated by those properly qualified for such work, not only by a knowledge of the various exercises suitable for general development, but also by the possession of an intimate acquaintance with the structures and functions of the human body.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### TWO CASES OF PLEURISY WITH EFFUSION.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
JANUARY 27, 1896.

By R. M. Ellyson, M. D.,  
Washington, D. C.

MR. PRESIDENT AND GENTLEMEN:—I report the following cases because I think we should sometimes record our mistakes as well as our successes. In both cases the symptoms were rather obscure, yet a more careful examination would have caused me to diagnose them correctly much sooner than I did.

CASE I. About 8 P. M., February 27, 1893, I was called to see H. C., male, white, aged 49, cabinet maker. His previous health had been good until two days before my first visit, when he felt chilly, tired and out of sorts; appetite poor; constipated. During the forenoon of February 27 he had a chill, followed by severe headache and high fever.

His temperature at 8 P. M. was  $105^{\circ}$ , pulse 100; tongue coated. I ordered a bottle of citrate of magnesia at once and five grains of quinine every three hours.

February 28. Temperature  $100^{\circ}$ , pulse 100; headache almost entirely relieved. Bowels had moved freely.

March 1. Temperature  $100^{\circ}$ , pulse 100. No headache; tongue still coated. Complained of pain in the region of the navel, radiating upwards in direction of liver.

March 2. Temperature  $101^{\circ}$ , pulse 100. Pains around navel worse. Ordered mustard plaster over seat of pain.

March 3. Patient about the same as previous day. I examined the abdomen and found that the right lobe of the liver extended two and a half inches below the lower edge of the lower ribs.

For the next week the patient's temperature ranged between  $100^{\circ}$  and  $101^{\circ}$ , pulse 110; constipated. Began to cough a little; expectoration very scanty. Patient persisted in getting out of bed and sitting by the stove, half dressed.

March 10. Had another chill, followed by high fever and sweating. I noticed a swelling over the right lobe of the liver about two inches below the ribs. Pressure caused deep-seated pain.

For the next four or five days the patient continued about the same, except the pulse rate increased to 120 and the swelling had increased in size and became more painful and red.

March 15. His temperature ran up to  $104.4^{\circ}$ , followed by profuse sweating.

March 16. Dr. Middleton saw the case with me and we diagnosed abscess of the liver.

March 17. Temperature  $101.4^{\circ}$ , pulse 140, respiration 30. Patient very much prostrated. The area of dullness extended from the fifth rib to three inches below the lower edge of the costal carti-

lages. I aspirated the liver in two places over the swelling, but obtained nothing except dark blood.

March 18. Patient's condition about the same, except he was entirely free from pain. I noticed that the apex of the heart was one and a half inches to the left of the normal place and for the first time I suspected pleurisy with effusion. My suspicions were confirmed by the area of dullness shifting with the position of the patient and by the tubular breathing on the right side.

March 27. The dullness had extended up to the second rib. Temperature  $99^{\circ}$ , pulse 140, respiration 36. Dr. Middleton and I performed paracentesis and drew off 40 ounces of sero-fibrinous fluid. Patient stood the operation very well.

For three or four days following the operation the patient had attacks of hiccoughs lasting from one to two hours. The cough also became worse. The temperature and pulse rate remained about the same; breathing not so rapid.

April 4. I aspirated again and obtained about a pint of fluid. The aspiration was slow and tedious owing to particles of fibrin repeatedly clogging the aspirator.

The patient gradually improved and April 15 the G. A. R. Post, of which he was a member, took him to the Hampton Home. At that time his temperature had been normal for nearly two weeks; pulse 100, respiration 24. Dullness in front extended up to the fifth rib.

July 10. I saw the patient and he told me that for a month he had been coughing up daily about one pint of purulent-looking expectoration. I did not see him again for over a year. He was then looking and feeling better than he had for over ten years.

CASE II. November 18 I was called to see A. H., female, white, aged 5 years. Her mother said she had been feeling badly for about a week and on the 16th she had a chill followed by high fever for a few hours.

November 17. She seems well; played around the house with other children.

November 18. She had a temperature

of  $103^{\circ}$ , pulse 120; tongue coated and bowels constipated. She complained of pain around navel. I ordered a purgative and quinine.

November 19, 7 P. M., temperature  $104.6^{\circ}$ , pulse 120.

November 20, 10.30 A. M., temperature  $102^{\circ}$ , pulse 120, respiration 40. Dry cough. On percussion the right side of the chest was perfectly flat, except a small area below the right scapula. For the next two weeks the patient's condition remained about the same, except that the temperature dropped to between  $99^{\circ}$  and  $100^{\circ}$ , pulse increased to 130 and respiration to 48.

December 8. Seeing no prospect of the fluid being absorbed, with Dr. Middleton's assistance I aspirated about one pint of fluid from the chest.

December 9. Temperature  $101.8^{\circ}$ , pulse 120, respiration 48.

The temperature fell to normal in a few days, but respiration and pulse remained the same for over a week. The patient then began to improve slowly but steadily. Six weeks after aspirating, the right side of the chest was resonant over the entire area.

The symptoms in both of these cases were very similar for the first few days. The location of the pain was very unusual; at least, I have never seen or heard since of the pain in pleurisy being referred to that spot. Evidently in both cases the inflammatory process commenced in the diaphragmatic pleura and as neither patient ever complained of pain in the chest, the inflammation may not have extended upward very far. I have been somewhat at loss to account for the swelling over the abdomen and the sudden cessation of pain after aspirating the liver in the first case. I would be glad if some of the gentlemen present would express their opinions on that point.

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IODINE IN PUERPERAL SEPTIC DISEASE.—G. A. Solovioff of Moscow (*British Medical Journal*), discussing the treatment of diphtheroid lesions of the womb and vagina in puerperal cases, highly recommends painting the affected areas with iodine tincture.

## A SMALL BUT USEFUL COMBINATION OF MEDICINES FOR VEST POCKET AND OFFICE USE.

By D. W. Cathell, M.D.,

Author of "The Book on The Physician Himself," Etc., Baltimore.

I HAVE, for several years, pursued a plan of furnishing a fraction of the medicine to my patients from my vest pocket and office, which has proven so satisfactory in every way, that I desire to bring it to the notice of others.

My armamentarium consists of four articles only, each of which I purchase cheaply in wholesale quantities. These are: 1. Sulphate of morphia, tablets  $\frac{1}{4}$  grain each, with  $\frac{1}{50}$  grain sulphate of atropia. 2. Gelatine coated sulphate of quinia pills, 3 grains each. 3. Round gelatine coated Dover's powder pills, 5 grains each. 4. Oviform gelatine coated compound cathartic pills.

The Dover's powder pills and the compound cathartic pills, being both black, are distinguished from each other by having one round and the other oval.

I carry a supply of all four in my vest pocket, in a screw top glass tube, similar to those used by druggists for dispensing lozenges. I mingle the three kinds of pills in this tube, and have simply to pour a few into the hand and select this or that kind when wanted, but the friable morphia tablets are kept separate, in a little tablet tube, to prevent contact and injury. This being small, is also carried in the screw top tube with the pills. The smallest size cash envelopes, costing but fifty cents per thousand, complete the outfit.

Among the good results of using this system and these articles are the following:

1. These four articles are all standard and reliable agents of the United States Pharmacopeia, with the many uses of which every physician is familiar, and are all neat, clean and easily carried.

2. One naturally becomes expert and quick in judging whether any one of the four can be beneficially given to the patient before him.

3. In many urgent cases the very best preliminary treatment can be instituted without delay or loss of precious time.

4. Neither of the four articles interferes with whatever additional remedies one may prescribe in conjunction.

5. Not only is good treatment promptly instituted in a case, but fewer drug store prescriptions are necessary.

6. By giving a fraction of the medicine yourself, the credit is somewhat divided, and the patient is not taught to wholly depend, both mentally and physically, on the druggist who holds the prescriptions.

7. By dissolving one, two or three of the morphia tablets in four, eight or twelve tablespoonfuls of water, one has a diluted, colorless and almost tasteless solution of that most reliable agent, with which to honestly meet any milder indication for it, *à la* homeopathic though it may appear.

8. The kindness and skill shown by using this method does much to attach patients to the physician, and although no direct charge may be made for remedies thus given, no one forgets them or their effects, and all naturally pay his fees somewhat more cheerfully than if paying solely for his lead-pencil and prescription-paper wisdom.

9. Giving a prompt and useful portion of the treatment not only creates confidence in the physician's knowledge and power, but also has a tendency to endear and exalt him, instead of subjecting him to the suspicion of being selfish or mercenary, as might follow systematic attempts to furnish all the drugs for his cases, while drug stores are near.

10. If a few of any variety are given at the office to be used later, the small envelopes above mentioned are both cheap and convenient for the purpose.

11. With such a combination, one can counteract the free dispensary, check-

mate the prescribing druggist and meet the homeopath to an astonishing degree. Indeed this little quartet has very materially assisted the writer to hold his own in practice against all such rivals.

12. I do not believe that any general practitioner who gives this simple plan a full and fair trial will ever abandon it.

13. Anyone can carry either these, or in lieu thereof, substitutes for them,

provided they do not exceed half a dozen articles in all, as his own judgment or experience may suggest; but if he increases the number of varieties so as to amount to a general outfit, carried in separate bottles, or in a regular medicine case, or provides a full supply for the continued treatment of cases, it thereby becomes a wholly different plan, with a different result from the little system I use and wish to recommend.

## CAN THE PRIMROSE (PRIMULAR OBCONICA) PRODUCE AN URTICARIA OR SIMILAR DISEASE?

*By Drs. Geigl and von Praag (Dordrecht).*

ABSTRACT, WITH PERSONAL NOTES, FROM "THE MONATSHEFT FUER PRAKTISCHE DERMATOLOGIE," BY ROBERT B. MORISON, M. D., BALTIMORE.

IN June, 1895, Dr. von Praag consulted Dr. Geigl about an affection of the face and hands in a lady who was of a highly nervous temperament. It had been of four years' standing. She had been healthy before this, she thought; but nevertheless a well-known gynecologist advised her to have some local treatment of the uterus.

The skin trouble, which came on periodically and lasted for several days, was marked by itching, pain and swelling and could be seen only on the face or hands. The eyelids were much swollen.

There was a diagnosis made of urticaria and acute edema. Atropine and valerian seemed to keep it in check for at least a year. Then again it appeared first in a mild form, then quite severely. A connection between menstruation and the skin eruption seemed possible, as the latter was worse during a period. In one attack the lids of the left eye were so much swollen that they could not be opened and the lower jaw was covered with bullae and vesicles. The inside of both hands were also affected. The skin was quite sensitive. Six weeks after, the same eruption appeared, and, because the patient complained of trouble in the genital parts, and for other reasons, a consultation with a gynecologist was advised.

After much treatment and quite a

severe operation the irritation on the skin did not disappear. Her husband, who was a gardener, suggested that it might be cured by some plant. He had noticed that some persons' skins were poisoned by the fur or hair which is part of the stem of the flowering primrose, and in this case it seems to have proven true, since his wife recovered when not touching the plant, but immediately relapsed when handling it.

### NOTES BY THE TRANSLATOR.

I have seen children who could not hold a ripe peach in the hand without urticaria. Strawberries poison others in the same way as do all fruits which grow upon the ground.

There have been several cases of acute dermatitis, which I have seen in my public practice, undoubtedly produced by the fumes of burning brush. Those of poison oak or rhus toxicodendron seem to be more poisonous than when green if the smoke from it is encountered. This may be that the smoke soaks into the clothing. The worst case I ever saw was on a man employed in Greenmount Cemetery to burn the weeds in the lots. His eyes, face, throat, mouth and all his skin were acutely inflamed. He could not see and was led by the hand.

Thus it would seem reasonable to

think, until disproven, that there is a poison which exists in certain plants and that it has an especial tendency to irritate the skin.

I trust I may call to the remembrance of some the bravado-trial of boys, who, when ready to jump into a stream on a hot summer's day, first rushed through a patch of poison-oak "to see if it would really poison them." It is often followed by much suffering. I must plead guilty to this sort of a trial, although one of the few who escaped. It took many weeks of suffering to cure the others who were poisoned, and it was with much pride that those who did escape walked daily through the uncertain

weed while the poor sufferers looked on with envy.

It seems to me that there might well be written a volume on what poisons the skin, not so much those things taken into the stomach as those to which children and their parents are constantly and unconsciously exposed.

The close air of the living-rooms, overheated by a furnace which carries with the heat the fumes from the cellar or kitchen, the sealed up chimneys without that vent for foul air which people had in years gone by, not only bring on trouble of the general health but most certainly are a factor in the troubles of the skin.

#### USE OF CITRIC ACID IN GONORRHEA.

— Among the newer remedies for the treatment of gonorrhea is the use of citric acid, as suggested by Pellissier, in the *American Medico-Surgical Bulletin*. He reports favorable results in the treatment of gonorrhea with solutions of citric acid. His reason for using it is that it is a parasiticide, and that gonococci cannot grow on an acid medium. He uses it in a one per cent. solution, injected into anterior urethra six times daily, or by irrigation in strength of 8:1500 up to 8:1000, in both anterior and posterior urethra, and claims that it causes little or no pain and no irritation. He reports fifteen cases successfully treated without complications.

\* \* \*

THE SEASIDE AND AFFECTIONS OF THE NOSE, THROAT AND EAR.—Lavraud of Lille (*British Medical Journal*) considers sea air injurious in general to nervous, excitable subjects, especially children, and to the rheumatic, arthritic and herpetic. On the other hand, it is, as a rule, beneficial to the tuberculous without fever, the lymphatic, the strumous, the anemic and those weakened by long illness or overwork. The diseases of the nose in which it is of benefit are chronic hypertrophy of the turbinates, recurrent coryza, ozena and suppuration of the sinuses of the throat, hypertrophy of the tonsils if not too

long standing; atonic catarrh and catarrh arising from overwork, as long as the subjects are not of nervous, arthritic or congestive habit; of the ears, only those chronic otorrheas kept up by bad general condition, lymphatism, struma or tuberculosis, tinnitus when due solely to a general condition for which sea air is indicated (overwork, etc.). Marine residence is to be avoided in otorrhea in general, in sclerosis of the middle ear and tinnitus aurium, and in the case of congestive, excitable and arthritic subjects.

\* \* \*

EROSION OF THE VESICAL MUCOUS MEMBRANE.—Delagénière states (*Medicine*) that in a man suffering from hematuria and much vesical pain, he made an incision above the pubes, opened the bladder, and found the mucous membrane so seriously diseased that he removed it entirely, leaving a drainage tube in the cavity for a few days. The man recovered and became able to urinate naturally. Later he died of pulmonary phthisis without any recurrence of the bladder trouble. Microscopical examination confirmed the diagnosis of tuberculosis.

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HEINZEL reports three cases of amblyopia (*Journal of the American Medical Association*) accompanying lactation that in one amounted to absolute amaurosis.

## Society Reports.

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### CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.

MEETING HELD JANUARY 27, 1896.

At the meeting of the Clinico-Pathological Society of Washington, D. C., held January 27, 1896, at the office of Dr. Tompkins, the paper of the evening was read by Dr. Ellyson, entitled A REPORT OF TWO CASES OF PLEURISY, WITH EFFUSION. (See page 415). The discussion was opened by—

*Dr. Compton*, who said that the subject of pleurisy with effusion never can be considered a simple thing. Many authors agree that all cases of pleurisy are due to bacilli. He thought that Dr. Ellyson should have had a microscopical examination made of the fluid drawn from the pleura, to determine if any bacilli were present. If a free and copious injection of boracic acid solution had been used after the aspiration, it would have been good treatment. When cases come under our observation a careful and complete examination should be made, not only of the seat of complaint, but the entire organism, and our diagnosis will usually be correct.

He classes cases of empyema under pleurisy. The position of the patient is very important in diagnosis. In a simple serous effusion, change of position will cause a difference in the local signs more quickly and markedly than in sero-fibrinous effusion.

Saline purgatives are contra-indicated in pleurisy. Calomel is much better; antipyrine and salicylate of soda are also highly lauded.

We need never fear that harm can be done by throwing fluids into the pleural cavity. He has used as much as eight quarts of boracic acid solution in irrigating the cavity, after aspiration. The gravity of these cases is dependent on the amount of effusion, its character and the complications that may exist.

*Dr. Frank Leech* recently saw a case of aspiration for pleuritic effusion. The instrument used was called the Alice Aspirator, and the operator withdrew

all the fluid at one sitting, in which he considered a mistake had been made; it would have been better to withdraw about one-third of the effused fluid at a time, taking several days in which to remove it all. He had seen several other cases of aspiration for effusion, but they were cases of long standing.

*Dr. Compton* said that there was just one point in the treatment of the disease that he wished to mention. The great importance of the recumbent position and perfect rest, particularly in recent cases.

*Dr. Van Rensselaer* referred to the first case of Dr. Ellyson, in which he suspected phthisis. His theory in the case was that the effusion had become purulent, broken into a bronchus and relieved the pleura in this way. Dr. Compton states that all cases of pleurisy are now thought to be due to bacilli; he did not know that in a simple pleural effusion bacilli were found.

Dr. Compton's method of drawing off all the fluid and injecting boracic acid solution into the cavity and allowing it to remain for several hours is new treatment to him and he does not see the rationale of it.

*Dr. Wellington* said that pain in pleurisy is often referred to the abdomen and not the chest. The great point to bear in mind in aspirating the fluid is that the pleural cavity must not be infected and thus convert a simple into a septic fluid, consequently even boracic acid solution is risky.

*Dr. Compton* said that the great advantages of the boracic acid solution washing of the pleural cavity were: All those effusions may or may not contain some of the pus-forming bacilli, and it is a perfectly safe antiseptic solution. Aspiration should always be followed immediately by the injection of the solution, whether the effusion in the pleura is purulent or not.

*Dr. Deale* said he thought it was gratifying to hear a man report some of his errors in diagnosis, as his were most natural mistakes and ones to which we are all liable. Pain and swelling in the region of the liver, with chills, would have suggested abscess of that organ.

Intermittent fever might have been diagnosed in the second case. Some authors hold that even serous effusions may be caused by bacilli, but this is not generally recognized.

He was surprised to hear from Dr. Compton that eight quarts of fluid could be injected into a pleural cavity. As to the use of boracic acid solution after aspiration of the pleura, he questions its germicidal power; plain hot water would be just as efficacious. Salines he considers very valuable in serous effusions by promoting absorption. It is surprising with what impunity we can aspirate the pleural cavity, although it does become infected at times; still in the large majority of cases this does not occur.

Dr. Compton said that there was one point about the treatment of cases of pleurisy he had not as yet mentioned; it was the use of active massage in place of blisters. Some counter-irritation can be produced in this way and it can be used every day; he thinks absorption can be as readily produced by this means as by blistering. The massage can be applied generally over the whole chest. The vast majority of effusions not containing pus-forming bacilli are recognized as tubercular.

Dr. Ellyson, in closing, said in reference to washing out the pleural cavity after aspiration, that he could see no indication for it in non-purulent cases; nor does he think that boracic acid solution exerts any antiseptic effect. He agreed with Dr. Van Rensselaer that in one of the cases cited the effusion must have broken into a bronchus and discharged in that way. He also admits that the patient may develop tuberculosis.

R. T. HOLDEN, M. D.,  
Secretary.

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**PROFESSIONAL CRAMP AND BRIGHT'S DISEASE.**—At a recent meeting of the Société de biologie, a report of which is noted in the *New York Medical Journal*, M. Bonnier stated he had found that professional cramp was a symptom which might indicate the presence of Bright's disease.

## Medical Progress.

### RECENT PROGRESS IN GASTRO-ENTEROLOGY.

By Charles E. Simon, M. D.,  
Baltimore.

#### LACTIC ACID IN THE STOMACH.

THE Significance of the Presence of Lactic Acid in the Stomach. (Julius Friedenwald, *New York Medical Journal*, 1895.)

Friedenwald examined a large number of cases with a view of ascertaining the validity of Boas' assertion that lactic acid in notable quantities is found only in cases of carcinoma of the stomach, provided that the patient is given a test-meal which does not itself contain lactic acid, and that the stomach be previously washed out. The method employed by Boas for the demonstration of lactic acid is based upon the fact that a solution of lactic acid, when carefully treated with strongly oxidizing substances, is decomposed into acetic aldehyde and formic acid. The aldehyde is then detected by the formation of iodoform in an alkaline solution of iodine.

No lactic acid was found in the 29 normal cases examined. In the 4 cases of superacidity (one case of supersecretion, one doubtful case of ulcer and two cases of nervous dyspepsia) the same result was attained. Of the 12 cases of atony slight traces only of lactic acid were found in one. Negative results were also reached in 6 cases of non-malignant dilatation, in 12 cases of chronic gastritis and 5 cases of secondary gastric catarrh referable to pulmonary tuberculosis and heart disease. In the 6 cases of cancer of the stomach, on the other hand, lactic acid was found in every instance, the amount varying between 0.11 and 0.31 per cent.

#### DISEASES OF THE STOMACH AND INTESTINES.

Demonstration of New Methods of Diagnosis and Treatment of Diseases of the Stomach and Intestines. (Fenton B. Turck, *American Medico-Surgical Bulletin*, 1895.)

Under the above title, Turck describes his gyromele, which consists of a

flexible cable, to the end of which is attached a sponge covering a spiral spring, which can be removed from the cable at will and changed. The cable passes through a rubber tube and this again is attached to a revolving apparatus for the purpose of producing revolution of the sponge, when the tube has been passed to the stomach. The esophagus, the sigmoid flexure, the bladder, the posterior nares and the uterus may be explored with similar instruments. The indications for the use of the gyromele are: 1. The removal of adherent material from the walls of the stomach. 2. The application of anti-septics and medicaments. 3. Direct internal massage of the walls of the stomach. 4. The application of an electrode to the entire stomach, so that every part of the organ is reached.

Turck has used this instrument very extensively and has found it to be of great utility in combatting chronic glandular gastritis. He also refers to some experiments of Weisner (Proceedings of the Illinois State Medical Society, 1895), according to which the gyromele will cause a return of secretion in an acidity. (It would be interesting to know the cause of the an acidity in these cases. Unfortunately the Proceedings of the Illinois State Medical Society are not always available.)

The second instrument which Turck describes he designates as his gastric motor-meter. This consists of a small rubber tube to one end of which is attached a small, oblong rubber bag. When this bag is introduced into the stomach, it is inflated and connected with a manometer and a recording cylinder, upon which tracings of the various movements are obtained.

The armamentarium of Turck finally consists of a nebulizer, a stomach needle-douche, a stomach-tube filter and a rubber bib with pouch.

#### DETECTION OF FREE HYDROCHLORIC ACID IN THE GASTRIC JUICE.

Some Observations Concerning a New Test for the Detection and Quantitative Estimation of Free Hydrochloric Acid in the Gastric Juice. (Julius Friedenwald, *Medical Record*, 1895.)

Friedenwald has carefully controlled the experiments of Töpffer, who recommended dimethyl-amido-azo-benzol as a most delicate reagent for determining the presence of free hydrochloric acid in the gastric juice. He finds that a positive reaction is still obtained in the presence of 0.004 per cent. of free HCl. in aqueous solution, showing that the test is more delicate than the resorcin test recommended by Boas and just as delicate as the phloroglucin-vanillin test of Günzburg.

With organic acids, such as lactic acid and acetic acid, a positive reaction is only obtained when these are present in amounts which are never found in the gastric contents. Acid salts and combined acids do not react with the reagent. The presence of peptones and albumens does not interfere with the delicacy of the test. Remembering, moreover, that the test is simpler than the resorcin or phloroglucin-vanillin test, it is clear that the dimethyl-amido-azo-benzol may be very advantageously employed in the place of the former reagents.

In practice it is only necessary to add one drop of a 0.5 per cent. alcoholic solution of dimethyl-amido-azo-benzol to a few drops of the gastric contents (filtration is not necessary), when in the presence of free HCl. a beautiful red color is obtained, while in its absence the mixture presents a distinct yellow color.

Friedenwald also points out that filter paper dipped into the solution of dimethyl-amido-azo-benzol may, when dry, be advantageously used as a test-paper for the detection of free hydrochloric acid.

He further confirmed the statement of Turck that the reagent may be conveniently employed as an indicator in the quantitative determination of free HCl. To this end 10 cc. of filtered gastric juice are treated with 3 or 4 drops of a 0.5 per cent. alcoholic solution of the reagent, and titrated directly with a  $\frac{1}{10}$  normal solution of NaOH, until the red color which develops at first gives place to a distinct yellow. The percentage amount of free HCl.

is then calculated by multiplying the number of cc. of the  $\frac{1}{10}$  normal solution employed with 0.00365, and the result with 10.

**ANIMAL LIFE IN THE ABSENCE OF BACTERIA  
FROM THE ALIMENTARY CANAL.**

Thierisches Leben ohne Bakterien im Verdauungskanal. (George H. F. Nuttall and Thierfelder, *Zeitschrift für physiologische Chemie*, xxii, page 109.)

Nuttall and Thierfelder have succeeded in demonstrating conclusively that animal life can go on in the absence of bacteria from the alimentary canal. A guinea pig removed by Cesarean section from the uterus of the mother animal under aseptic precautions was placed in a sterilized glass cage and nourished for a week with sterilized food. The air which the animal breathed was likewise sterilized. During this week the animal consumed about 330 cc. of milk, and appeared to be normal in every respect. Its weight at the conclusion of the experiment was 83.0 grammes, while that of the control animal was 85.2 grammes. At the expiration of a week the animal was killed, when a microscopical examination of the intestinal contents revealed an entire absence of bacteria; culture experiments were likewise negative.

As to the very ingenious manner in which the experiment was conducted, the reader is referred to the original.

The results obtained stand in direct opposition to the view held throughout his life by Pasteur and others. Heretofore it was thought by physiologists that the products of bacterial activity which are found in the intestinal contents, viz., certain aromatic acids, volatile fatty acids, phenol, cresol, indol, skatol, carbon dioxide, hydrogen, methane, sulphuretted hydrogen, etc., constituted an important factor in the production of normal peristalsis. This view in the light of Nuttall's experiments will have to be abandoned.

**THE MECHANICAL ACTION OF THE STOMACH.**

Ueber das Verhalten der mechanischen Action des Magens. (M. Einhorn, *Zeitschrift für Klinische Medicin*, xxvii, page 242.)

With the view of ascertaining the part played by the muscular contractions of the walls of the stomach in the comminution of the food, Einhorn made a series of experiments with an instrument especially devised for the purpose, which he terms the gastrokinesograph or gastrograph. This apparatus consists of a hollow metal ball, a few electric cells and a registering apparatus. The ball measures half an inch in diameter and contains in its interior a second, solid ball, provided with little spikes projecting in all directions, none of which, however, connect with the sides of the hollow ball. With the latter it is connected only by one small rod, and through this with the battery by means of two fine wires. In the interior of the hollow ball there is also a small platinum ball, which can freely roll about in all directions. At the least movement the platinum ball will come into contact with one of the little spikes and at once close the current; as soon as it moves away the current is broken. It is manifest that there will be no change in the current, if the ball remains at rest, while any movements of the ball will be registered at once.

With the aid of this instrument it was shown that the contents of the stomach are almost continuously moved about under normal conditions. Under pathological conditions it was shown that the movements of the stomach are either normal or nearly so, increased or diminished in intensity.

Further experiments are necessary in order to demonstrate the practical value of the method in diagnosis.

**NEUROTIC VOMITING.**

Neurotic Vomiting. (Robert T. Eedes, *Canadian Practitioner*, 1896.)

Under the above title Eedes relates two cases which ended fatally.

The first occurred in a woman, aged 41, who for more than a year had persistent vomiting. There had been during this time but one or two intermissions. The vomiting took place without reference to the time of eating. There were no cerebral symptoms, and there was no reason to suspect the kidneys. She became emaciated and died.

At the autopsy the lungs were found to contain small cheesy deposits. The heart was small but otherwise normal. The stomach showed nothing abnormal, the pylorus was not obstructed. The kidneys and other organs were normal.

The second case occurred in a female, who had always been delicate and subject to sick headaches. Five years ago a pain began in the right side. Two and a half years ago her health began to break down entirely, with insomnia, headache and a stomach trouble. Obstinate vomiting occurred. She took no food or drink excepting a glass of water from time to time to "rinse out her stomach," but which, without effort, she threw up again at once. During this period she once took a little broth and a minute piece of fish, which were thrown up again, undigested, thirty-six hours afterward. For some thirty days preceding her death no food was taken, excepting by enema, although she was vomiting in small quantity.

During her whole sickness her mind was perfectly clear until two days before death, when she fell into a mild delirium. There was no vomiting of blood, the bowels were regular, the urine contained no albumen, but was highly concentrated. At the autopsy the body was found much emaciated. The heart and lungs were normal. The stomach contained no tumor and no ulceration. There was some congestion of the vessels and some ecchymoses "undoubtedly originating about the time of death." It was nearly empty, with no large amount of mucus and presenting no extraordinary appearance to the naked eye. The intestines had fecal contents. The liver was normal, pancreas normal, spleen not enlarged. The kidneys were congested, but otherwise normal. The right semilunar ganglion was apparently normal, the left not found. The pelvic organs were normal.

It is to be regretted that no record of a systematic examination of the gastric contents is given and that a microscopical examination of the stomach walls was neglected, but this was not feasible at the time.

#### ABSENCE OF GASTRIC SECRETORY FUNCTION.

D. D. Stewart. A Clinical Study of Three Cases of Persistent Absence of the Gastric Secretory Function. *The American Journal of the Medical Sciences*, 1895, pp. 560-585.

Under this title Stewart describes three cases of atrophy of the gastric tubules.

In the first case, occurring in a female patient, aged 52, symptoms of indigestion were not complained of. There was no decided evidence of anemia, no icterus and no wasting. An examination of the gastric contents after Ewald's test-breakfast usually showed an acidity of from 2-5; at times a neutral reaction was noted. On one occasion, although the stomach was cleansed by lavage before the roll-breakfast, a decided Uffelmann reaction was obtained from the filtrate; the total acidity was 18. Traces of the milk-curdling ferment and of its proenzyme were always present. Pepsin was absent, while pepsinogen occurred in traces. It frequently occurred that food from the evening meal was present in the fasting stomach in the morning. It is interesting to note that the arthritic complaints of the patient disappeared entirely after treatment of the condition of the stomach, and particularly the impaired motility.

The second case occurred in a woman aged 35. Attacks of extreme physical prostration, each of several month's duration, had here occurred for four years, characterized by weakness, loss of appetite, breathlessness on exertion, cardiac palpitations, pallor and severe attacks of syncope. A blood examination revealed 2,300,000 red corpuscles, with 40 per cent. of hemoglobin. No cause for the anemia could be found; gastric complaints were not made, although a history of occasional spells of vomiting in former years, sometimes lasting for weeks, was obtained.

An examination of the gastric contents revealed an acidity of from 2-5. HCl. absent. Pepsin and pepsinogen, as well as chymosin, absent; chymosinogen only in traces. After appropriate treatment a very slight pepsin formation was noted. An examination of the mo-

tor power of the stomach was unfortunately not made.

The third case likewise occurred in a female, aged 32. Gastric symptoms, viz., anorexia, distress after all food, nausea and not infrequently vomiting, etc., had existed for five years. Epileptic seizures appeared at the time when the gastric symptoms were first noticed. Patient is a profound neurotic. She often has an afternoon temperature of  $102^{\circ}$ - $102.5^{\circ}$ , which is not accounted for. An examination of the blood showed 4,000,000 to 4,500,000 red corpuscles and from 40-50 per cent. of hemoglobin. An examination of the gastric contents showed a very low acidity (equaling only that of the food taken). No traces of pepsin with the usual method, while with that of Jaworski traces were obtained; chymosin always absent; chymosinogen in minute traces.

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**THE TREATMENT OF SOFT CHANCRE.**  
—The following treatment is recommended in the *Therapeutic Gazette*. Every morning the ulceration should be touched with a tampon of cotton wet in this solution :

Menthol, gr. j;  
Carbolic acid, gr. v;  
Alcohol, f 3 iss.

Aristol is next dusted on and a piece of absorbent cotton applied, thus completing the dressing. The patient is directed to wash the sore several times with carbolic acid solution and to dust with aristol. All friction or causes of congestion are to be avoided.

Phagedenic ulcer is touched with solution made up of :

Cocaine, gr. j;  
Potassio-tartrate of iron, gr. xv;  
Distilled water, f 3 iss.

It is next powdered with a mixture of 20 parts iodoform and 5 parts menthol; and potassio-tartrate of iron is given internally.

\* \* \*

**THE MERCURIALS.**—In a very exhaustive article on the mercurials in the *Journal of the American Medical Association*, by Dr. S. V. Clevenger of Chicago, the following conclusions are drawn :

1. Mercury acts mechanically as a deobstruent upon the glands and lesser tubular structures, by virtue of its unstable chemical properties, its volatility and great weight.

2. Its condition in the fluids and tissues is that of finely divided globules of the metal numbering upward of one thousand million (one billion, French) to the cubic centimeter, and as a vapor of the metal. In whatsoever form it may be taken, it is quickly precipitated as mercury, and without change is excreted or retained in the system, mainly in the bones.

3. It cleanses the intimate visceral tissues by projecting from them materials of less weight, and in this way breaks up, removes or prevents morbid accumulations. In excess it occludes the tubular parts and may produce any of the phenomena attending stasis of vital operation anywhere about the body, such as ulceration, congestion, paralysis, anemia, etc.

4. The liver and inferior maxillary region for anatomical, and the former for physiological, reasons receive most of its primary influences.

5. It can be given in larger doses in warm weather or climates, because heat favors its elimination, systemic effects decreasing necessarily in proportion.

6. Its antiphlogistic properties are merely deobstruent and detergent.

7. Its value in syphilis is owing to its acting in the line of least resistance, breaking up any nidus the disease may form. The ability of the metal to envelop and carry microorganisms gives it an ameboid or phagocytic value. In phagedenic ulcerative processes it would be contraindicated, because the degeneration is too rapid to be effectually reached by mercury, which is not the case in slower-forming specific ulcerative stages. Its administration in these diseases could be regulated by the rapidity of degradative processes. Comparatively slowly acting morbid centers, or those of a congested nature, could be improved by mercury where the drug would only accelerate rapid tissue destruction.

8. It is tonic, by increasing red blood globules whose formation has been pre-

vanted by glandular perversion, the metal removing the obstructions toward their formation, while in overdoses anemia is produced by occluding the vessels it, in small doses, cleansed.

9. The solubility and consequently superior penetrability of the bichloride is probably productive of the mercurial characteristic effects which seem out of proportion to the amount of metal in doses of this salt; but it is not to be denied that chemical or direct neurotic influences coöperate with the metal in the more active preparations, and thus possess features of their own.

10. Experimental evidence is opposed to probable formation of any compound in the body, and supports the belief that decomposition invariably and almost instantaneously follows its ingestion with the precipitation of mercury as minutely divided globules, from any preparation of which it forms the base.

\* \* \*

#### RETRO-DEVIATIONS OF THE UTERUS.

—Dr. Augustin H. Goelet of New York (in a paper presented at the New York State Medical Society) believes that many of the operations designed for retro-deviations of the uterus are unnecessary and irrational. The objection to Alexander's operation is the time it consumes and the prolonged convalescence it entails. Both ventro-fixation and vaginal fixation substitute an abnormal position and leave the organ fixed. When the uterus is movable, opening the peritoneal cavity to overcome a displacement is not justifiable if a cure can be effected without it. This should, he thinks, be reserved for those cases where the organ is fixed in an abnormal position by firm adhesions which cannot be otherwise overcome, and in these cases the uterus should be suspended from the anterior abdominal wall not fixed to it. This secures the organ in a nearly normal position of anteflexion, and it is fairly movable.

Vaginal fixation has been given undeserved attention in this country. Its originator, Mackinrodt, has abandoned it. When it is more generally known that the fixed abnormal position which

results offers a serious impediment in pregnancy when it supervenes and complicates labor, it will cease to be recognized as a legitimate procedure.

Where the uterus is movable, Goelet dilates carefully, curettes the cavity, and inserts a straight glass drainage tube, which serves the purpose of a splint and keeps the uterus straight. The vagina is then tamponed with iodoform gauze in such manner as to throw the organ temporarily into a position of anteflexion. Subsequently, a vaginal pessary is made to take the place of the tamponade. The tube is retained in the uterus for a week, during which time the patient is confined to bed, but it is removed every day and the cavity is irrigated to remove mucus and clots which may be retained. When the patient is permitted to get up, the tube is permanently removed and a vaginal pessary is employed for a while to maintain the uterus in a correct position until the normal tone of its walls and supports is restored.

When the adhesions are not very firm or extensive they are broken up by manipulations under anesthesia without opening the peritoneal cavity and the case is then treated as one of movable displacement.

This seems a rational procedure, since it aims at a cure of the metritis and endometritis, the maintaining cause of movable displacements; re-establishes a normal position of the uterus, and leaves it movable. It is entirely free from risk if thorough asepsis is observed and requires only a week's confinement in bed.

The uniform success which this plan of treatment has afforded in his hands leads him to believe that the other more hazardous and complicated operations designed for retro-deviations are generally unnecessary.

\* \* \*

**BACKWARD CHILDREN.**—It is becoming more clearly recognized, says the *Lancet*, that children are not all cast in one mould and that there is a large class to whom intellectual exercises are more difficult than to others and whom

it is absurd to force through the same educational curriculum as the average child. But the difficulty confronting teachers in which they look for assistance from the medical profession is this: How are these children to be recognized and how is disability to be distinguished from disinclination or laziness? Before these questions can be answered observations will have to be made on a very large number of children, both normal and backward. A paper giving the result of observations made on 100,000 children was read on the 18 ult. before the Royal Statistical Society by Dr. Francis Warner. The records of cases had been analyzed and grouped, the records being made on specially designed cards indicating the points to which the attention of the observer should be directed. The labor involved in the resulting tables must have been enormous, and they will form an invaluable basis for future work on the subject. But it deals with groups and merely indicates the needs of individual children. As Dr. Warner says, "further observations and research are still much needed to afford material for the study of the individual defects and the results of variation in environment both in London and elsewhere." A most useful society, the British Association for Child Study, has been in existence for a few months, formed chiefly of teachers and parents for the express purpose of making continuous observations and records of individual children. The society has the active assistance of several well-known physicians in drawing up schemes for recording observations, and the results after a few years' accurate observation will be collated, tabulated and published by the society.

\* \* \*

SHOULD ONE SLEEP AFTER EATING?  
—We would not now revert to this oft-discussed question to give any one's theoretical views or personal beliefs in the matter, or to bring forward the familiar argument that because animals sleep just after they have eaten, hence the human animal should do the same. Dr. Schule of Fribourg (*Medical Record*)

has, however, approached the subject from the chemico-experimental side and his results are worthy of record. Having analyzed the stomach's contents in two normal subjects a few hours after meals, some of which were followed by sleep and others not, he finds that sleep has for its constant effect the weakening of the stomach's mobility and at the same time there is an increase in the acidity of the gastric juice. On the other hand, simple repose in the horizontal position stimulates the motive function of the stomach but does not increase the acidity of the gastric juice. The conclusion is hence reached that, while one should stretch himself out for a rest in the horizontal decubitus after a hearty meal, he should resist the tempting Morpheus, especially if there be present a dilated state of the stomach or if its juices be hyperacid.

\* \* \*

MUSIC AND BALD-HEADEDNESS.—*The Boston Medical and Surgical Journal*, says the *Medical Record*, calls attention to the fact, which it says is demonstrated by an English statistician, that music has a wonderful influence on the growth of the hair. This statistician has discovered baldness to be prevalent in 12 per cent. of composers, which is about the average for people in general. Instrumental performers, however, always retain their hair up to an advanced period of life. Players on the piano and violin have particularly good heads of hair, and the aggressive example of Paderewski at once comes into one's mind in support of this assertion. On the other hand, brass instruments have a fatal influence on the growth of the hair, notably the cornet, French horn and trombone. The baldness which prevails among members of regimental bands has been given the name of "trumpet baldness." Our contemporary does not venture to explain this curious phenomenon, but simply quotes these facts. If well established, no doubt they will give a tremendous impetus to the use of the piano and violin. Doctors, it adds, are the baldest of all professional men, the percentage being 30.

MARYLAND  
**Medical Journal.**

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BALTIMORE, MARCH 28, 1896.

THE relation between occupation and disease has long been recognized, and physicians have often been handicapped in their treatment of

*Occupation and Constipation.* disease, or a diseased condition in an individual by his

occupation. Dr. H. L. Winter reports, in the *American Medico-Surgical Bulletin*, several cases of intestinal obstruction in cork cutters from which he concludes that the constrained and bent position necessary in this work was the real cause of the obstruction. It is certain that constipation is often brought on, not only by a constrained and bent position, but by any occupation in which there is little exercise.

It is against this lack of exercise and deprivation of fresh, unused air that the physician has to fight. Many diseases or pathological conditions would turn of themselves towards the normal and recovery would be the result, if poor abused nature were only given a half chance. Indeed it is wonderful, and much more than man deserves, to see

how insulted nature will return again and again to the rescue of ignorant and careless man, and how attention to common sense rules will bring about a cure even after the cause of the trouble has persisted for a long time.

As a physician, a sort of uncut diamond, said recently in an exchange, "O Woman, thy name is constipation." The women are most prone to this evil, and not so much from their occupation as from their manner of dress, lack of exercise and indolent habits in their attention to the calls of nature. Men are by their position and by nature of their sex more active and less subject to the evils of constipation, but that some do suffer from this trouble because of their confining and constrained occupation Dr. Winter has shown.

When man fails to take the proper amount of food and rest and in other ways offends against Dame Nature, sooner or later punishment comes.

\*\*\*

THE time is again near at hand when the annual meeting of the State Society will be held, and it is hardly too

*The Medical and Chirurgical Faculty.* soon to call attention to the importance of preparing for this meeting now, and especially because the renewed vigor of the Faculty in its new home will naturally attract a larger number of members who will come to see the new library, the new halls and the increased facilities.

The great number of medical societies which are held over the whole country naturally makes it difficult for any one society to hold the attention especially long, but it has always been considered a duty as well as a pleasure to take an interest in the State society. Arrangements have not been completed for the annual address, but there may be every assurance that a good man will be procured.

What papers will be presented by individual members are yet unknown, but it is probable that the members from throughout the State will be present, and whether they read papers or not they will certainly take part in the discussions, and for this reason the committee on programme should take care not to crowd the meeting with a large number of papers which are only put down for show, and probably many of them have never been even thought out.

A few well digested and thoroughly discussed papers do more lasting benefit to the hearers than many long and elaborate addresses, which are passed over in silence.

\* \* \*

THE American Academy of Medicine will hold its twenty-first annual meeting at Atlanta, just before the meeting of the American Medical Association. The Academy began in a very modest way, and for years its work made little impression, but of late the influence of this strong society and the effect of its discussions have been felt in every medical school in this country.

The plea was formerly raised that the college bred medical man was no better than any other physician, and in fact many maintained that the time spent at college and medical school unfitted a man for work, and gave him a start too late in life. The advances in medical education throughout the country have shown that the medical schools have felt the need of better educated men, and by lengthening the terms and raising the standard and requirements for admission, the chaff is being gradually weeded out and the fittest survive.

At the meeting at Atlanta in May, many important and practical papers will be read. The President, Dr. Henry M. Hurd of Baltimore, will open the meeting by a paper on "Laboratories and Hospital Work," and his position at the Hopkins Hospital and in the medical school well fit him to speak with authority.

In the ten minute papers, Dr. J. McPherson Scott of Hagerstown, of the Maryland Board of Examiners, will talk on State Examinations, and Dr. George H. Rohé will speak of the best method of teaching State Medicine. The meeting promises to be a successful one and strongly attractive to the advocates of advanced medical education.

\* \* \*

THE City Health Department has just issued a very instructive little circular giving the necessary precautions

*Precautions in Contagious Diseases.* to be taken against the contagious and infectious diseases. First it is shown how the diseases are spread; then the periods of incubation are paraphrased. The liability to catch disease is shown, and

those persons most likely to fall victims. Some general precautions are given, not only how to avoid these diseases, but what to do in the sick-room; what to do during convalescence; what precautions should be taken in regard to burials; and what disinfection is necessary after recovery or death.

The standard disinfecting fluids are given, with general directions how to disinfect a room. The circular is short and clear and is in plain language for the people. Such instruction is necessary from time to time, and when it is authoritative and from a sanitary office it should be regarded.

Such directions cannot take the place of a physician, a nurse, or even of a sanitary inspector, but many persons can help the cause of disease restriction by following out carefully the plan stated in this little bulletin, and thus save many a susceptible person from catching a disease which may mean death or a lasting complication.

\* \* \*

THE true value of any discovery can hardly be estimated until the first waves of enthusiasm have passed away.

*The Roentgen Rays.* The hurry with which so many would-be investigators rush into print, especially in the daily press, show how many crude opinions and statements are made as to the results obtained or the possibilities which in part have to be retracted.

The skiagrams of the hand and foot were the first ones made public and the ease with which needles, bullets and other foreign bodies could be located was manifest. Further than this, there is much speculation and it is a very significant fact that Roentgen himself has been very little heard of in the latest statements.

Meanwhile, it will be found that the truly scientific man will work on in silence until he has some new facts to communicate, while the bungler, anxious for a name and shining with reflected glory, will continue to astonish the world, chiefly through the sensational press, as to what he intends to do.

If the public would only let such work alone until it was ready to be announced, and if ignorant men could only be suppressed, many a discovery in any department of science would stand a much better chance of benefiting the whole world.

## Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending March 21, 1896.

Diseases.	Cases Reported	Deaths
Smallpox.....		
Pneumonia.....		30
Phthisis Pulmonalis.....		20
Measles.....	10	2
Whooping Cough.....	13	3
Pseudo-membranous Croup and Diphtheria. }	11	8
Mumps.....	2	
Scarlet fever.....	5	1
Varioloid.....		
Varicella.....	1	1
Typhoid fever.....	2	1

The University of Buffalo has adopted the four years' course.

Dr. Harry Friedenwald has resigned from the Bay View Board.

The mutual accident insurance companies find that bicyclers are bad risks who shall pay large premiums.

Needle baths will probably be introduced in the city jail. They are a great improvement over the old tub baths.

The Lehigh Valley (Pa.) Medical Association held its eighth winter conversational meeting at Allentown on January 30.

The physicians of London, Ontario, have entered into an agreement whereby one and all refuse to do contract lodge work any longer.

Medical Inspector Edward Kershner has been dismissed from the service by the President. He was accused of falsehood and was court-martialed.

The American Academy of Medicine will meet at Atlanta, May 2 and 4, just previous to the meeting of the American Medical Association.

The publishers of the *Medical Record* will put on a special car from New York to Atlanta provided a sufficient number of physicians will join the party.

Göttingen has thirty-one women students this winter semester. They study history,

mathematics, modern languages and natural history, and for the first time at this university a woman is studying medicine.

Dr. C. A. Hollingsworth was reappointed health officer at Belair, Maryland. Dr. Silas Scarboro was appointed physician to the almshouse at the same place.

Nearly one-third (15,000 out of 50,000) of the men who wanted to enter the British army last year were rejected on account of defective eyesight, bad teeth, or flat feet.

Dr. Yung Mung Fueng, a graduate of the Royal Medical College of Canton, was recently registered as a practicing physician in St. Louis, and will open an office there.

A number of admirers of the late Dr. Charles Carroll Lee of New York have contributed \$10,000 to endow a ward in the Post-Graduate Hospital, to be named after him.

The fund for the Leidy Fellowship of Anatomy has reached the encouraging sum of \$12,000, and it is hoped that the entire amount of \$30,000 will be realized before the close of the year.

Dr. A. P. T. Grove, a prominent physician of Dallastown, Pa., committed suicide in Baltimore last Monday. Dr. Grove was a graduate of the University of Pennsylvania and a member of the Philadelphia County Medical Society. He was forty-two years old.

Dr. George H. Rohé has resigned his position as Superintendent of the Maryland Hospital for the Insane, usually called "Spring Grove," and will take charge of the new insane hospital to be built at Springfield. Dr. Percy Wade will probably succeed him.

The faculty of the medical department of Tulane University, New Orleans, La., has announced the election of Dr. A. L. Metz to the Chair of Chemistry and Medical Jurisprudence, to fill temporarily the vacancy in that body caused by the death of the late Dr. Joseph Jones.

Arrangements are being made by the Section of Neurology and Medical Jurisprudence of the American Medical Association, at their Atlanta meeting, in May, to have the medico-legal possibilities and bearings of the Roentgen rays upon medicine and surgery presented in an elaborately illustrated lecture. Several newly-discovered facts will be stated and unusual attention will be devoted to this topic.

## WASHINGTON NOTES.

From the Health Department, the report for the week ending March 14, 1896, is as follows: Apoplexy 2, bronchitis 5, congestion of lungs 1, consumption 18, convulsions 1, diphtheria 2, diseases of brain 4, diseases of heart 13, diseases of kidneys 13, malarial fever 1, malignant growths 5, measles 5, meningitis 2, pneumonia 10, typhoid fever 1, miscellaneous 34, la grippe 4, total 121. The number of persons who died during the last week exceeded that of the previous week slightly over 7 per cent. A review of the meteorological condition shows that the average temperature was at the freezing point and that a constant range of low barometer prevailed, with a high relative humidity. The death list, under these conditions, went up from 112 to 121, and the death rate from 21.2 to 22.8. During the corresponding period of last year it was 19.4. The principal features of the week's sickness were 13 deaths from diseases of the circulatory organs, 13 from affections of the kidneys, 5 fatal cases of measles and 4 from grippe. With the exception of 1 death from typhoid fever and 2 from diphtheria, no fatal case of zymotic disease occurred. There was a decline of 14 in the mortality from acute lung diseases and an increase of 5 from consumption. Seven new cases of diphtheria were reported, 4 houses were removed from quarantine and 19 houses remained placarded. Of scarlet fever, 9 new cases were reported, 4 houses were released from quarantine and 25 houses remained placarded. Of the total deaths, 20 occurred in hospitals, 8 were certified by the coroner. Births 104 and marriages reported 30, of which 18 were white and 12 colored.

The next regular meeting of the Medical Association of the District of Columbia will take place Tuesday, April 7, 1896, at 8 o'clock P. M., in the Law Building of the University of Georgetown, on E Street, between 5th and 6th Streets, N.W. Thirty names of applicants for admission will be balloted on, which is a much larger number than usual.

The Clinico-Pathological Society held its regular meeting on March 17, the President, Dr. H. B. Deale, in the chair. Dr. L. W. Glazebrook read the paper of the evening, entitled "The Modern Treatment of Sprained Ankle-joint." He presented a plaster model,

with adhesive strips of plaster in place, illustrating the subject.

The Medical Society of the District of Columbia held its regular meeting on Wednesday evening, March 18, the President, Dr. Samuel C. Busey, in the chair. Dr. I. S. Stone read a paper on "Movable Kidney." Dr. J. W. Bové presented specimens of ovarian cyst, ruptured tubal pregnancy and hysterectomy for fibroids.

The regular meeting of the Washington Obstetrical and Gynecological Society was held on Friday, March 20, the President, Dr. George Byrd Harrison, in the chair. Dr. G. N. Acker read a paper entitled "A Case of Congestion of the Spinal Cord, with Recovery, followed by Typhoid Fever, with some Interesting Points." It was discussed by Dr. E. L. Tompkins, after which Dr. M. F. Cuthbert reported a case of post-partum hemorrhage.

## Book Reviews.

MEDICAL DIAGNOSIS WITH SPECIAL REFERENCE TO PRACTICAL MEDICINE. A Guide to the Knowledge and Discrimination of Diseases. By J. M. DaCosta, M. D., LL.D., President of the College of Physicians of Philadelphia, etc. Pp. 1104. Illustrated. Eighth edition, revised. Philadelphia: J. B. Lippincott Company. 1895.

In the preface to the first edition of this classical work, the author said: "My chief aim in writing this work has been to furnish advanced students and young graduates with a guide that might be of service to them in their endeavors to discriminate disease." This was written thirty-two years ago and the profession of America and England will bear testimony that this work has fulfilled the author's expectations, for it has been the light which has guided the way of many a medical man groping in the dark. In this, the eighth edition, many changes have been made since the seventh appeared, and this has been principally in the realm of the diagnosis by means of the microscope, as in diphtheria, typhoid fever and the blood diseases. Several new wood cuts and fever charts have been introduced and many of the chapters have been slightly altered to suit the times. This work will always be a help to the student, so clear are its descriptions and thorough its teachings. It is much larger than previous editions, which is a disadvan-

tage. This work has been translated into other languages.

**THE PATHOLOGY AND TREATMENT OF VENEREAL DISEASES.** By Robert W. Taylor, A. M., M. D., Clinical Professor of Venereal Diseases in the College of Physicians and Surgeons, New York. In one very handsome some octavo volume of 1002 pages, with 230 engravings and seven colored plates. Cloth, \$5.50; leather, \$6.50. Philadelphia: Lea Brothers & Co., Publishers. 1895.

This exhaustive work of Dr. Taylor's is written in a most painstaking manner, and he has gone over the appalling amount of literature on the subject very thoroughly. The many ways of treating acute gonorrhoea are referred to and their advantages or disadvantages are stated. The pathology of this disease is extremely interesting, and would fill a volume in itself alone. The true clinical value of the gonococcus is given, and a warning is sounded against mistaking the pseudogonococcus for the specific organism. The plates and illustrations of the organism and infiltrated tissues are especially good. After passing over stricture of the urethra and chancroid, the author devotes the remainder of the book to syphilis, the skin lesions of which are fully and well illustrated. The treatment of syphilis is carefully given and the hypodermic method is explained. This is a very valuable work.

#### REPRINTS, ETC., RECEIVED.

**The Bacteriology of Dengue.** By J. W. McLaughlin, M. D. Reprint from the *Texas Medical News*.

**Chronic Seminal Vesiculitis, with Hemorrhage.** By S. P. Collins, M. D. Reprint from the *Cincinnati Lancet-Clinic*.

**The Osteopathic Fad.** By A. J. Steele, M. D., of St. Louis. Read before the Missouri State Medical Association, May 21, 1895.

**The Kinetic and Therapeutic Energy of Drugs.** By J. W. McLaughlin, M. D., Austin, Texas. Reprint from the *Transactions of the Texas State Medical Association*.

**An Outline of the Physical Theory of Fermentation, Immunity and Infection, and its Bearing on the Rationale of Serum Therapy.** By J. W. McLaughlin, M. D. Reprint from the *Transactions of the Texas State Medical Association*.

#### Current Editorial Comment.

##### PERSONALITY IN EDITING.

*Medical Mirror.*

I AM a firm believer in the thought that there can be no well conducted medical journal without a personal head to it, a head that is interested in it from start to finish and a head that is willing to be held responsible for the creature in all of its details. I have no patience with the headless medical journal, the one that is edited impersonally and for which nobody is responsible. It may be well classed under the head of bastards.

##### WHY MEDICINE IS PRESCRIBED.

*Medical Age.*

To THE unprejudiced observer it must be clearly apparent that two-thirds of the prescriptions given by physicians are as harmless as mother's milk; many of them would make devils laugh and angels weep. The doctor is not as much to blame as might be supposed; on the contrary, he is to be commended; the patient very naturally expects to be treated with medicine, and if the doctor does not dose him he is discharged as one who does not understand his business, and some one else is secured who is less scrupulous.

##### MISUSE OF MEDICAL WINES.

*American Medico-Surgical Bulletin.*

THE medicated wines to be recommended with caution are the elixirs and wines that are heavily charged with alcohol, and which may also contain opium, cocaine, etc. The use of cocaine has rapidly spread during the last three or four years, chiefly through ignorance on the part of the public and the profession as to its possible dangers. This habit has been started in two ways; first, by incautious and promiscuous use of cocaine solutions as a nasal or throat spray, and by giving prescriptions for such solutions to the patient to be used *ad libitum* for colds, catarrhs, etc.; second, through the too common use, without medical advice, of the popular wines containing coca or cocaine in some form. Thus they have gained an extensive patronage among those who suffer from nervousness or weakness of any form.

# MARYLAND MEDICAL JOURNAL

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## Original Articles.

### GENERAL PARESIS.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
FEBRUARY 4, 1896.

By *Sterling Ruffin, M. D.*,

Professor of Medical Jurisprudence and Demonstrator of Anatomy in the Medical Department  
Columbian University, Washington, D. C.

GENERAL paresis is a chronic cerebral disease of remittent type, characterized by dementia of gradual onset, frequently merging into mania or melancholia, with stupid and expansive delusions, accompanied by tremor, ataxia, pupillary alterations and eventual paresis. The various synonyms are general paralysis of the insane; progressive general paralysis; general paralysis; paralysis of the insane; paralytic dementia and paretic dementia.

I am fully aware of my inability to say anything new on the subject. The purpose of this paper is to consider the disease from the standpoint of the general practitioner rather than of the neurologist; and my only endeavor will be to briefly review the latest and best teachings, and to append a short report of a case not long since under my care.

The disease was first described in 1822 by Bayle, who believed it to be an arachnitis. During the following thirty years it was, for the most part, written of by Frenchmen, but in 1854 it was described by Erlénmeyer of Germany as an atrophy of the brain, and has been so considered ever since. It has been much written of during the last few decades and the literature of today is very voluminous.

Microscopically, the morbid anatomy, as summarized by Bevan Lewis, than whom there is perhaps no more eminent authority, consists of: 1. A stage of inflammatory change in the tunica adventitia of the arteries with excessive nuclear proliferation, profound changes in the vascular channel and resulting trophic changes in the surrounding tissues. 2. A stage of extraordinary development of the lymph-connective system of the brain, with a parallel degeneration and disappearance of nerve elements and axis cylinders. And 3. A general contraction of the newly formed connective tissue with resulting atrophy to an extreme degree of the parts involved.

Microscopically, the changes are: 1. Increase of the cerebro-spinal fluid and edema of the pia mater, together with thickening and opacity of the meninges, which are adherent in places and tear the cortex if an attempt be made to remove them. 2. Atrophy of the convolutions, especially of those of the frontal and parietal lobes. The brain substance, especially the cortical portion, cuts with firmness. The ventricles are dilated and their lining membrane, the ependyma, extremely granular. In addition there are frequently areas of softening or hemorrhage associated with

chronic arterio sclerosis. And 3. Spinal alterations, consisting chiefly of a secondary descending degeneration of the pyramidal tracts due to destruction of their trophic centers in the sclerosed cortex.

Bearing in mind these extensive anatomical changes, a moment's reflection is sufficient to suggest a correspondingly extensive symptomatology; and as a matter of clinical experience it is a fact that there is scarcely any symptom met in any other mental disease which may not be found in this.

The clinical history may be conveniently divided into three periods, namely, the prodromal, the maniacal or melan-choliac, and the demented.

The prodromal stage is the most interesting one to the general practitioner; it is during this stage that the disease is usually under his care. The prodromal period may extend over months, or even years, and during its continuance the symptoms are generally remittent and insidious. Mentally, they consist of changes of character, which are often vague and transitory, or of intensifications of previously existing mental traits. Loss of memory, unusual irritability and inattention to business, sometimes amounting to apathy, are often among the earlier symptoms. A naturally cautious man may suddenly become fond of reckless speculation, or an amiable, affable man morose and disagreeable; while, on the other hand, an economical man may suddenly become penurious, a generous man extravagant, a moral man fond of lewd women, and so on.

Contemporaneously with these mental symptoms are physical ones which are often so slight as to escape attention. Chief among these are tremor and speech and pupillary alterations. The tremor usually begins in the tongue or facial muscles, but sometimes in the extremities. If the tongue be protruded a series of slight contractions of the lingual muscles may be seen. In the extremities the tremor can best be detected by gently supporting the tips of the patient's fingers, if the upper extremity is being tested, or the heel, if

the test is being applied to the lower extremity, in the examiner's palm, the limb, whether arm or leg, having been first extended and placed at right angles to the patient's body. In this way tremor, even though it be slight, may be appreciated by the examiner as a series of gentle muscular contractions.

The speech defects consist either of a slurring over certain words or letters or of a general indistinctness of pronunciation, or of both, and are due to an inability to coördinate the muscles of phonation. Frequently it happens that a paretic patient can pronounce individual words correctly, but the ataxia is evident when he attempts to read a sentence or in ordinary conversation. The letter "r" is specially difficult to pronounce. A very good test is that suggested by Dr. Landon Carter Gray to ask the patient to repeat after you the sentence, "around about the rough and rugged rocks the ragged rascal ran."

The pupils may vary from normal in size, contour and the reaction of the iris to light and accommodation. In about one-half of all cases they are dilated; in the majority of the remaining cases they are of moderate size; and contracted pupils are said to be of rare occurrence. In about 50 per cent. of all cases they are unequal. This symptom, that is the inequality of the pupils, is apt to escape observation, for it is frequently remittent, the periods of remission, during which the pupils are equal, lasting in some cases for several weeks. The pupil may respond to light very sluggishly or even be immobile; and likewise it may react sluggishly or not at all with accommodative movements of the eye.

The patella reflex varies in the majority of cases, being exaggerated, slight, sluggish or abolished. Temporary incontinence of urine is an occasional early symptom.

These are the prodromal symptoms briefly enumerated, and they are more or less constant. There is a characteristic tendency to paroxysmal exacerbations, the mental defects, the speech alterations, the tremor and pupillary abnormalities becoming aggravated. As

time goes on, the symptoms become intensified. The ataxia, which was perhaps at first only noticeable in the speech, is now detected in the extremities. The hand-writing changes and the tip of the finger cannot be brought quickly into contact with the tip of the nose, if the eyes be closed. The muscular strength is unimpaired; the grip of the hand is as strong as ever.

These prodromal symptoms are of special importance medico-legally. An early diagnosis will frequently save much suffering to the patient, his friends and relations, and his business interests.

Sooner or later and gradually or suddenly, the second stage, that is the stage of mania or melancholia, is reached. In this stage there is, in addition to the symptoms of the preceding one, a mania or a melancholia, which, whether it be one or the other, is distinguished by certain definite characteristics from other manias and melancholias. In the mania cases there is associated with the usual maniacal delusions and hallucinations a stupidity or lack of logical reasoning; and along with the stupidity there is a highly characteristic illogical expansiveness or exaggeration of ideas. I had under my care at one time a man who believed that he had all the sand in the District of Columbia accumulated in one immense pile and that with his corner on sand he was going to control an immense cement trade. I now know a paretic dement who believes that he is possessed of all the coffee in the world. When asked how he acquired it and why it is that his position in the world is not more consistent with his magnificent wealth, he stupidly replies that all the coffee is his. This stupidity is very characteristic. It is in striking contrast to the fine-spun, plausible reasoning accompanying the grand conceptions of the paranoiac. The mania is apt to be very violent, sometimes ending fatally from exhaustion. The melancholia cases are to be distinguished from acute melancholias by the fact that the melancholia of general paresis is not accompanied by the obstinate insomnia and post-cervical ache so characteristic of melancholia generally. There are often

suicidal tendencies, however, and the hallucinations and delusions are of the same gloomy, depressed type ordinarily found in melancholia.

The second stage gradually passes into the third, that is the stage of dementia. The stupidity has progressed to a positive lack of mental faculty. Mentality may be almost entirely abolished, the unfortunate subject being little more than an automaton.

Throughout the three stages epileptiform or apoplectiform seizures may occur. There may be losses of consciousness, partial or complete; convulsions, localized or general; paralysis, hemiplegic or monoplegic, sometimes only affecting speech. Usually in the beginning of the second stage there is a perceptible loss of power of the muscles of the extremities, especially of the legs. This loss of power is at first apt to be paroxysmal, but is progressive and may increase until there is in the last stage a complete paralysis of all the extremities.

Before passing to the etiology of the disease, there are a few unclassified symptoms yet to be referred to which are of interest and worthy of note. One of these, an eye symptom, is a variety of mental blindness. Single letters are recognized and can be named, but when combined in a word they are not recognized; and it is the same with simple objects. Ophthalmoscopic examination is usually negative; but occasionally it shows a primary optic nerve atrophy. Another one of the symptoms relates to the sense of pain. This is usually acute in the first stage and hyperesthesia and neuralgia are of frequent occurrence. Later there is apt to be anesthesia, which may be very marked. Mickle reported a case in which the anesthesia was so complete that a patient chewed his finger without pain, but with such vigor that it became gangrenous and had to be amputated. The operation was done without any anesthetic, general or local, and during its performance the patient looked stupidly on without concern or evidence of pain.

Lines reported the case of a man who seized a live coal and held it in his hand

sufficiently long to produce a severe burn. The anesthesia of general paresis is a frequent explanation of the parboiling accidents occurring in insane asylums.

Among the many causes of general paresis, the chief ones are sex, age, heredity, social position, other diseases of the brain, cranial traumata, climate, locality and race, syphilis, alcoholism and chronic lead poisoning. Women are attacked much less frequently than men, a circumstance probably due to the fact that men are more exposed and more addicted to excesses and vices than women. The ratio is about one to four.

The disease usually occurs between the ages of thirty and thirty-five, occasionally as early as six and sometimes as late as sixty.

Direct inheritance is rare; the inheritance of a neurotic temperament frequent.

Occupation and mode of living are a causative factor of the utmost importance. The exposure and fatigue incidental to military and naval service are said to favor the development of the disease; but perhaps the most frequent cause is, in the words of Mickle, "a life absorbed in ambitious projects, with all its strongest mental efforts, its long-sustained anxieties, deferred hopes and straining expectations." The mode of living so frequently observed in the business men of large cities, so aptly and thoroughly expressed in the phrase, "burning the candle at both ends," is undoubtedly productive of many cases, especially in combination with excesses in eating, drinking and sexual indulgence. An overwhelming majority of all cases occur in married people.

In this country at least the disease is more common among the more intelligent and the well-to-do classes. In the French army, it is claimed by Colins, three-fourths of the cases of insanity among the officers were due to paralytic dementia.

Other insanities occasionally merge into general paresis and injuries to the cranium are beyond doubt an occasional cause.

The etiological relations of climate,

locality and race are interesting. The disease is rare in Ireland, many of the large asylums being without a single case. It is almost unknown in the Belfast institution, where, it is stated by Mickle, "the population is chiefly of Lowland Scotch origin and really of Saxon blood, while the Celts of Wales, Cornwall and the Scotch Highlands have a considerable share of the disease." On the other hand, the Celts of the South of Scotland are rarely affected by it. In the South of France the disease has increased during the last half century. If it existed in this country prior to 1843, it was not recognized. Dr. Workman states that when he entered the Toronto Asylum in 1853, there was not a single case in that institution, but that from January, 1865, to July, 1875, there were 72 deaths from this disease alone. In Portugal its relative frequency is about three per cent. of all insanities. In Rio Janeiro there were 11 cases in 297 insane. In Australia it is of frequent occurrence. In Cuba it is rare and attacks the negroes much more frequently than the native whites.

Syphilis is admitted by most observers to be a frequent cause, but it has been conclusively shown that there is a form of cerebral syphilis closely resembling paralytic dementia, and designated by Fournier as syphilitic pseudo-general paresis, which may be caused by focal lesions of the cortical and sub-cortical regions of the cerebrum, causing fusion of the cerebral membranes and leading secondarily to cortico-meningeal infiltration.

Among other causes may be mentioned chronic alcoholism and chronic lead poisoning.

The vagueness of the early symptoms makes a diagnosis in the commencement extremely difficult. It is often impossible to say whether slight alterations in conduct are due simply to one of the varying moods to which we are all subject, whether they proceed from deranged digestive functions or other temporary disturbance, or whether they are the commencement of this serious disease. But we should invariably look with suspicion upon patients who have

not reached middle life and who have been previously vigorous, mentally and physically, if they begin to show a loss of interest in their affairs or an impaired ability to attend to them; if they become variably absent-minded, heedless or indifferent; if they are less capable of attention and concentration; if their perception and judgment are perceptibly impaired; if exertion is followed by unusual mental or physical fatigue; if their emotions have become intensified and less easily controlled; and especially if their ability to grasp things that are new is diminished, although they may be fully equal to their usual daily routine.

After the disease becomes well developed, its recognition is, as a rule, not difficult. It should be remembered that it is really a gradual dementia, complicated by stupid delusions, often expansive in nature; by pupillary alterations, by motor symptoms which are ataxic in the early stages and later paralytic; by tremor of the tongue and facial muscles and later general tremor; by a peculiar slurring or indistinct pronunciation; and, in most instances, by a melancholia of unusual type, or a mania with delusions of grandeur. These symptoms, in combination, go to make up a clinical picture not seen in any other disease. It should be remembered, too, that the disease is of a distinctly remittent type. Acute exacerbations, lasting one or two days, or more, during which the symptoms are intensified, are frequent, while on the other hand, the periods of remission may last for so long a time as to encourage the delusive hope of recovery.

There are cases of cerebral syphilis which very closely resemble general paresis, but which are yet distinct from it. In such syphilitic cases the speech and tongue are not, as a rule, affected in the way characteristic of paralytic dementia; epileptic seizures are more common and are more apt to be of the Jacksonian type, and the delirium of grandeur and the stupidity of general paresis are rare. On the other hand, there are instances of true general paresis which follow so closely and so surely

syphilitic infection, that a causal relation between the two diseases must be acknowledged.

Primary dementias usually occur earlier in life than general paresis and the dementia is of an entirely different type. The suddenness of its development is in striking contrast to the gradual and insidious onset of paralytic dementia. The primary dementia, so far as its mode of development is concerned, is explosive in character—it is full-blown from the first; and in primary dementia the ataxia, the pupillary alterations and apoplectiform and epileptiform seizures are wanting.

Secondary dementias are always, as their name suggests, secondary to, and the terminal conditions of, other insanities. Their history sufficiently explains their character.

Alcoholism is to be distinguished by its history; by the relatively acute onset of its symptoms; by the fact that the delusions are severer and more logical than those of general paresis; and by the further fact that the delusions are usually of a suspicious and incredulous nature. It must be remembered, however, that prolonged chronic alcoholism, like syphilis, may produce a true general paresis.

The prognosis is grave. But few cases of recovery have been recorded. The average duration is from three to five years, but cases have terminated in a few months, while others have lasted many years.

The treatment is prophylactic and palliative.

I can conceive of no obligation more binding than the physician's duty to warn the men and women under his care against excesses, whether of eating, drinking, sexual indulgence, work, mental or physical, exposure, or what not. How many invalids whose ill health can be traced to some imprudence or excess? How many inmates of asylums whose maladies have the same unnecessary origin? Of the whole catalogue of chronic nervous diseases, there are few against which there is a surer safeguard than a moderate mode of living. This is especially true of general paresis and the preventive treatment can almost be

summed up in the one word "moderation." In the case of syphilites we should advise not only a temperate life, but it is of the utmost importance not to allow them to conceive the idea that they are well, however completely their symptoms may have disappeared, until they have submitted to a thorough and prolonged course of specific treatment.

The palliative treatment is of more interest to the alienist than the general practitioner, for cases sufficiently far advanced to require it are usually fit subjects for confinement in an asylum. The first point to be determined is whether there is a history of syphilis. If so, large doses of iodide of potash alone, or in combination with mercury, offer a hope of arresting the disease and possibly of curing it. Among other remedies which have been recommended are ergot, quinine, warm baths, the bromides, hyoscine and hyoscyamine, veratrum viride and electricity.

In July, 1893, Mrs. H. came to my office to consult me in reference to her husband. I had known Mr. H. for several years. He was a native of the South, a clerk in one of the Government Departments, a man of moderate physical proportions, rather nervous temperament, gentle disposition, indefatigable energy and extraordinary ambition. Previous health, though not of a very robust type, had been fairly good. On one or two occasions I had treated him for temporary digestive derangements. Age 31 years. Family history good. In the preceding June he had completed his second year in the law school. His salary from the Government was small, and in order to provide for his family, consisting of a wife, three children and a sister, he had found it necessary to earn money from other sources. During the two preceding winters he had acted as stenographer for two congressmen, so that with his work for the Government, his law studies and his stenography, he was literally burning the candle in the middle as well as at both ends. His wife reported that during the preceding few weeks she had noticed an irritability of temper which was so foreign to him that it had alarmed her, that his appe-

titite had been capricious, and that he had lost flesh to some extent.

On the day following Mrs. H.'s visit I called at the patient's house. He greeted me as usual, but seemed somewhat annoyed, I thought, at my coming. I was unable to discover any ailment other than a slight gastric catarrh. I prescribed for him some of the ordinary aids to digestion and advised him to take a few days' rest, to eat very deliberately and to restrict his diet. After some persuasion I prevailed upon him to leave town for a short vacation. Upon his return he seemed to have made some progress and his wife reported that she had been able to note the improvement. In spite of my earnest endeavors, he returned to his old routine of writing all day and the greater part of the night. In the following autumn he began his third year at the law school and later resumed his stenography.

I saw him no more until March, 1894, when I was called to his house. I found him in a state of considerable excitement, of which he seemed to be fully aware, but for which he could offer no explanation. There had been some dissatisfaction, I was told, at his office because of his indifference to the duties which had been assigned him. His facial muscles twitched perceptibly and there was such inequality of his pupils as to readily attract attention. I considered his condition serious and so informed his wife.

Without going too much into detail, it is sufficient to say that arrangements were made through the generosity of an uncle for him to leave off his work and go away for an indefinite period, with the hope that with prolonged rest his mental and physical vigor would be restored. After the early part of April, 1894, I saw him no more until the following December, although I had frequent reports concerning his condition. Examination had failed to reveal any evidence of syphilis and there was no syphilitic history. During his absence, however, he took for several weeks, at my suggestion, liberal doses of iodide of potash.

The reports which I received were that physically he had improved to a very great extent, but that mentally, notwithstanding temporary improvements, he had on the whole lost ground. His hands had become tremulous and his pronunciation noticeably indistinct, and there was an intermittent but increasing tendency to the indulgence of extravagant fancies. In October he had an epileptiform convulsion, which was repeated in November.

In the latter part of December he was again in Washington, now on his way

to his home. His mental deterioration was very perceptible and there was more or less general tremor.

Two months later, his wife wrote me, he had rather suddenly become violent, and his removal to an asylum had been found necessary. He is still in the asylum, where, I am informed, his condition has gradually gone from bad to worse. He firmly believes that he has all of the sand in the District of Columbia heaped into one pile and that his revenues from the cement business will be without limit.

## A REMEDY FOR THE DISPENSARY ABUSE.

READ AT THE STAFF MEETING OF THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL.

*By Arthur D. Mansfield, M. D.,*

Member of the Staff of the Presbyterian Eye, Ear and Throat Charity Hospital, Baltimore.

DEEMING the above subject of such vital importance and not wishing to tag it on the conclusion of a rather lengthy article on "The Present Dispensary System," I therefore take it up separately.

It must of necessity be a conceded fact that our dispensaries are abused, before the remedy can be applied. The diagnosis has been made; auscultation and percussion reveal a hidden abscess. Our probe of investigation, if we pass it deep enough, reveals a putrefaction and rottenness that extend to the very core. Our dispensaries are abused without any question. What then is the prognosis? The prognosis is very grave. What then is the treatment? Like every other treatment for grave maladies, heroic measures are necessary.

Who would think of trifling with a malignant growth? The person is accounted foolish who trusts other than radical measures for the extirpation of that which if left alone will destroy even life itself; the parasite will evict the host from its temple, so with this dispensary abuse; if it is allowed to grow and germinate in the minds of the public, both adult and child, male and female, indeed all classes of society,

sooner or later will be infected with the dire malady of getting something for nothing. And when we awake to the realization of what should be done, thinking then something should be done, we will find that it is too late. It is never too late to do good but always too late to repair injuries and wrongs already done.

Men generally agree that dispensaries are abused. So much is granted—then the natural question follows, can it be corrected? I believe it can be done! The objection urged so many times is that what we want is concerted, unanimous and uniform action on the part of all dispensaries and medical men generally. We hear this objection on every side. What we want is nothing of the kind. Can you cite an instance of any great reform that was accomplished by a concerted, unanimous and uniform action upon the part of those injured by the needed reform? Don't you know that every reform is born and fostered by someone or more who are possibly looked upon as enthusiasts on the subject at first? Was any reform ever accomplished except by persistent efforts? Did Martin Luther, Savonarola, John Knox and many others await the con-

certed, unanimous and uniform action of the Christians of their day? No; they saw the need of reform and urged it and having firm convictions clung tenaciously to them.

The fault is not indigenous to the medical profession that they will not stand together for their own mutual good and welfare. We find the same fault in every class of society. Of course we hear of a want of uniform action on the part of the medical profession. It never was in any class that some few did not follow this way and others another way and the majority remain lethargic and prefer slumber to action, especially when that action is radical.

If the medical profession waits until every medical man, or even the majority, will aid in reforming this abuse it will wait until doomsday, for they will never coöperate. And if every dispensary in this city waits until every other dispensary, or even a majority of them, joins it in correcting these abuses, why the abuses will grow fat and obese upon the idleness of the enemy.

Very few medical men and even lay members but have more or less touch in this question of dispensary abuse. Some are directly connected with hospitals and dispensaries, either on the staff or the managing board, others recommend patients to hospitals that pay their bills for services rendered. So I take it that most of my readers have more or less touch in this question of dispensary abuse. If we are not on the staff of one or more of our hospitals and free dispensaries, do we exercise discretion in sending patients to our free institutions?

No, it is the old principle—as for me I will do what conscience and my mind dictates as right. If we know that we as participants in this abuse are encouraging this abuse, are we not personally and individually to blame? Do we grant that we in our official capacity in a dispensary are abused and misused? If we are, why do we allow it? Why do we remain so lethargic? Why so inactive and blind to our mutual interests? Why not arise and wipe out this abuse so far as we individually are concerned? Do we honestly and conscientiously do

all we can to correct and nullify these abuses?

Many cases that come under our notice are personally known to us. We see many at our dispensaries that we know can and do pay for general treatment and yet they receive treatment at our hands gratis. Why is this? Is it because we are too lax in bestowing treatment? Why do we allow it? The class of people in our dispensaries is more cosmopolitan than ever and I venture to make the statement that at least 50 per cent. are patients that can and ought to pay *something*. Don't you think that we had better treat one-half the number of patients and treat deserving ones and treat those properly, than treat such large numbers in the way dispensaries must necessarily treat them to finish in any respectable time allotted to dispensary work? Would it not be more creditable to our institutions and more beneficial and more profitable to the doctor and patient? In any plan, whatever, for the correction of these abuses we must bring our minds to this state—viz., that dispensary and hospital reports must make a big drop; we cannot hold the same increasing rate each succeeding year. According to conservative estimates, at least, the drop must be in the neighborhood of 50 per cent.

The laity is becoming suspicious of such reports of large numbers treated. In cases of hospitals supported by donations, donators know that donations are abused in so far that instead of helping deserving people, the donation aids in making possible the treatment of people who can and ought to pay, and consequently donations are falling off and justly so. I take this to be due to two causes: firstly, donators, if visitors at the hospitals and dispensaries at all during working hours, can see the class of people that are treated, and while some may be deceived, many are not, and seeing the misuse and abuse of their donations, refuse to continue to give. Secondly, donators become very often seekers after charity themselves at our dispensaries and finding how easily they can be treated without any questions,

immediately conclude that anyone and everyone can receive treatment just as freely, and draw the inference that charity must be a farce and refuse to contribute further. They conclude rightly, for charity as dispensed is a farce and a snare and delusion.

I hear someone say that they will only go to another dispensary. What if they do? Are you responsible for what another hospital does? It reminds me of the man who, knowing stolen goods were presented to him for purchase, bought what he knew he should not because, if he did not buy them, his neighbors would, and so he bought them just to keep his neighbor from doing it; he helps a fellow man to steal again and makes himself an accomplice. So with the man in the dispensary that treats anyone gratuitously, whom he knows to be able to pay—he helps that one on the road to pauperism and is an accomplice in their dishonesty.

Now, my plan for the remedy of this existing evil is as follows: Briefly, a blank with printed questions, somewhat similar to the subjoined, which, when answered and retained by the hospital, will serve as reference for the particular case treated and also as reference should anyone desire to make inquiries as to whether the case was a worthy one or not, should suspicions arise.

COPY OF BLANK IN USE AT THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL, 1007 EAST BALTIMORE ST.

This dispensary is a charity supported in whole and conducted by private individuals and not by the State or city. The surgeons of the staff receive no compensation for their work. It is for the poor only. All persons unable to pay for professional services are welcome. Those whose circumstances are such that they can pay moderate fees will be refused treatment and are cautioned against applying. This blank must be filled out and if the answers are satisfactory the individual whose name it bears will receive free treatment at this dispensary.

1. Full Name and Address.....
2. Age.....
3. Employment of self or person upon whom you are dependent?.....

4. By whom are you employed?.....
5. What is the name of the physician who attends you in ordinary cases of sickness? .....
6. Give reasons why you should receive free medical advice and treatment in this dispensary?.....

The object of this card is to protect the dispensary from imposition. Information obtained from these answers goes no further than the physician in charge.

The copy of questions given is now in use at the Presbyterian Eye and Ear Hospital. It is an effort in the right direction. How it will work is not as yet known, but with a united effort on the part of the staff much good may come of it. Briefly, a printed blank, similar to the subjoined, is to be handed any and all suspicious applicants; these blanks are to be handed by the members of the staff themselves, so that as much discretion and tact can be exercised as is possible, and by polite verbal questions, the sensibilities of worthy applicants cannot be offended. This blank is intended to find out the financial condition of the applicant or of the one upon whom the applicant is dependent, as in the case of children and women. The object of this blank is twofold; it informs the staff officer of the hospital of the financial condition of the applicant and, secondly, prevents fraud and lying by the element of writing and thus giving opportunity of investigation should any suspicions arise in the mind of any of the staff officers. Dispensary men soon "smell a rat," so to speak, and can generally "spot" unworthy cases as soon as they appear.

Some cases that apply to dispensaries need urgent treatment. Of this class let treatment be given and also the blank, with the request that upon the return visit the blank must be filled. If the case is a worthy one, no harm is done; if an unworthy one, treatment should be refused at the dispensary. There is a very prevalent idea that dispensaries are supported by the State and city. Some are and some are not, and from this idea the public generally draw the conclusion that they are for their

benefit, whether they are able to pay or not. They draw the inference that if they can be treated free, it is better than paying for it. But the majority of cases that come for aid to our free dispensaries would suffer no physical inconvenience by being compelled to fill out a blank with proper questions before treatment is given them.

The simple explanation that it is necessary to protect the hospital from abuse that this measure is taken would be sufficient. I firmly believe that the vast number of unworthy applicants would never return when they find an obstacle placed to their entrance and a barrier to be overcome before they can be treated. Patients find access to dispensaries entirely too easily. All they have to do is push open the door, walk in, be treated, and walk out, and the more "cheek" and "push" they have, the more quickly they can be treated and the sooner they can get back to their business. Put before these "worthies" some personal inconvenience and see how the evil would remedy itself. The abuse exists because the hospitals and free dispensaries make no decided effort to correct it.

Many cases that are worthless recipients of charity appear on the very face and aspect of the applicant, without any blank being filled or questions asked: Police officers and letter carriers brazenly come with their uniforms on, ladies dressed well and children showing culture and refinement, merchants (not petty ones), jewelers, lawyers, justices of the peace, book-keepers, men able to ride bicycles and even bring them into the dispensary so that they will not be stolen, men and women wearing diamonds. I call to mind one instance of a man who applied to the "Eye and Ear" for treatment and instead of putting his 2 karat diamond in his pocket he turned the stone into the palm of his hand and thought he kept his hand tightly closed, but the diamond reflects light in such a manner that makes it valuable. Needless to say that patient was turned away, and as subsequent events showed, properly too. It is nothing unusual to see, at hospitals, diamonds and sealskins and

other evidences of at least moderate circumstances.

This class is growing and increasing, it is not smaller this year than last year. This year the great influx of school children that fill our special dispensaries for the treatment of the eyes has greatly aggravated the question, and while the question of free fitting glasses does not appeal to the general practitioner as it does to the oculist, yet the primary and early lessons of obtaining something for nothing is inculcated and evil spreads apace and the free general dispensary is only a few doors away from the free special dispensary. Not one can say "I have nothing to do with this question of dispensary abuse." I say it touches every one. The evil can be remedied and ought to be remedied and that at once. Now, especially, do I urge upon young men to study this question of dispensary abuse. Especially do I urge upon young men good enough to do the mass of work in our dispensaries but not good enough to be recognized outside of the dispensary walls. Who does the mass of work at our dispensaries? Who gets all of the credit? The young man does most of the work and the elder gets all of the credit. The young man is a savant in the hospital and a "numbskull" and "amateur" in his office.

The writer, seeing the urgency of something to be done to correct the growing evil seen at the Presbyterian Eye and Ear Hospital, urged upon the members of the staff the expediency of a meeting of the surgical staff to consider the question and, if possible, arrive at some definite conclusion as to what should be done, and carry out the plans. A very full meeting of the staff was held the evening of February 18, 1896, and after the free discussion of the matter presented in the above paper the accompanying blank was formulated as the outcome of the meeting. We are making efforts to try the scheme at the dispensary and the writer is unable to give any information as to how it is going to work, but every confidence is had in the efficacy of the plan, even though in embryo and passing through the experimental stage. This evil is not one

that has just arisen in our midst. It has existed for seven years, to the writer's personal knowledge, since in hospital work that length of time. The time is ripe for the needed reform.

The quintessence of the thought is just this: Have a printed blank, the exact questions thereon are immaterial; what is needed is a means of finding out the financial condition of the applicant, the object being to place an obstacle in the way of unworthy applicants, with

the idea of making free dispensary treatment less easy to obtain than it is now, believing that many will stay away rather than undergo the annoyance of questions and answers. Again, when a definite plan is tried by one institution, the belief is that others will rapidly follow.

Résumé. Importance of the topic, urgency of a remedy to be applied, decision upon a definite plan and, finally, an adoption of that plan.

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**CREDÉ'S METHOD IN OPHTHALMORHEA NEONATORUM.**—R. Köstlin (*American Medico-Surgical Bulletin*.) The author has collected elaborate statistics from the large clinics of Europe and America showing the prevalence of ophthalmorhea neonatorum before and after the use of Credé's method of dropping 2 per cent. solution of nitrate of silver into the conjunctival sac of new-born babies.

Without prophylactic treatment ophthalmorhea was present in from 3 to 50 per cent. of the cases confined in the various clinics, the average being about 10 per cent. Since the introduction of Credé's method, 24,724 cases show that the percentage has fallen to 0.655.

Various attempts have been made to find something to supplant nitrate of silver. Carbolic acid, which was first used, was discarded on account of bad results.

Bichloride of mercury has been used in something over 2000 cases, and gives results as good or better than Credé's method, but has the disadvantage of causing considerable irritation. Stratz reports 0.42 per cent. of ophthalmorhea among 460 cases, while catarrh was present in 1.8 per cent. and irritation in 18.3 per cent.

Irrigation with sterilized water gives results less satisfactory than either nitrate of silver or bichloride of mercury, and the danger of injuring the eye is quite as great as in either of the other methods. Hoffmeyer reports one case of severe corneal ulcer from washing the eye with water.

Trichloride of iodine has been tried

in several hundred cases, but gives results even less satisfactory than any of the above methods.

The author thinks that silver nitrate gives the best results of all the methods yet tried, and that it has been used in cases enough to establish its value beyond a doubt. It is so easy of application and harmless in its action that it may be used as a routine by midwives.

Regarding the time of infection, he thinks it takes place during the passage of the head through the parturient canal, and not from material adhering to the eyelids or introduced into the eyes by water during the first bath, and supports his opinion by reporting several cases of prolonged labor in which children were born with well-established ophthalmorhea. Any method which simply cleans or disinfects the eyelids at the time of birth is not scientific, and is bound to give poor results.

The disadvantages of Credé's method are very unimportant. Corneal affections are not observed, and irritation is seen less often than with other methods. The eyes are not rendered especially liable to a late infection, and when a late infection does occur, it usually means that the infection was already present in the eyes, but development of the germs was retarded by the silver nitrate.

Credé's method has been adopted by most large lying-in hospitals and since its use has been so universal the decrease in blindness due to ophthalmia neonatorum has been very marked.

## Society Reports.

### CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.

MEETING HELD FEBRUARY 4, 1896.

At the meeting of the Clinico-Pathological Society of Washington, D. C., held February 4, 1896, at the office of Dr. Wilmer, the paper of the evening was read by Dr. Ruffin. Subject, GENERAL PARESIS. (See page 433.)

*Dr. Kelley*, in opening the discussion, said the subject was to him a foreign one, as far as experience was concerned. Alcoholism and syphilis are given as causes in the greater number of cases. Alcohol injected into the stomach of dogs caused about the same changes in the brain as in the brain of the human being affected with general paresis. From 70 to 80 per cent. of all cases of general paresis are ascribed to syphilis. He would like to hear from some member about the use of surgical means in the treatment of this disease. Operations on the brain and spinal cord for drainage of effusion seem not to have been successful. He would like to hear from Dr. Bishop on the subject of electricity in the treatment of this disease.

*Dr. Bishop* said the subject was covered very thoroughly by Dr. Ruffin's paper. General paresis always tends to a fatal termination. Remissions occur, but a return to former habits and haunts causes a return of the disease. The premonitory symptoms extending from a few months to a few years, as given by Dr. Ruffin, is not the general experience. A few months is usually the duration of the premonitory stage. He does not think that melancholia is a marked symptom in general paresis of the insane; usually happy ideas prevail, and memory being defective, they do not dwell on trouble but live in the enjoyment of grand hallucinations. General paresis of the insane does not follow other forms of paralysis; it is the primary disease. In the alcoholic dement, says Dr. Blanford, no pupillary changes, no hyperemia of the retina, are found.

*Dr. Snyder* had seen quite a number of cases during his service in an insane

asylum. He agrees with Dr. Bishop that general paresis begins as general paresis, and has a short incubatory stage. The prognosis is always bad; about ten years is the average duration of the disease. The causes might be summed together under the head of excesses. The delusions of grandeur that are characteristic of the disease are firmly fixed, apparently latent at times, but constantly recurring. One symptom omitted by Dr. Ruffin is the practice of patients of burrowing in the bed and grinding the teeth, so that you can walk through the hospital at night and hear these unpleasant sounds.

*Dr. Tompkins* said there were one or two things in Dr. Ruffin's paper with which he did not agree. Melancholia is usually absent, and for this reason general paresis is the happiest form of insanity. Anemia of the brain, which Dr. Ruffin mentions as one of the early conditions of the disease, comes on later, the first stage being one of congestion. He does not remember the grinding of the teeth, except in alcoholics. Patients affected with general paresis get down as low as it is possible for human beings to reach, and have no realization of the necessity for cleanliness and order. In regard to remissions, he knew of one patient in whom the remissions were so marked that he returned to work, but soon broke down and died.

*Dr. Clark* agreed with Dr. Ruffin that melancholia was a symptom of general paresis, but does not agree with him in his description of the way it comes on. Dr. Ruffin defines general paresis as a cerebral disease. It is both cerebral and spinal. He enumerates many symptoms that simulate general paresis of the insane; chronic meningitis must also be differentiated. About 75 per cent. of the cases are due to syphilis. Syphilis is also a great etiological factor in locomotor ataxia, so that this explains why men outnumber women four to one in being affected with general paresis.

*Dr. Ruffin*, in closing the discussion, said that in regard to operations for the relief of pressure in this disease he could see no good reason for such treatment of the brain of insane patients. There is

no doubt that quite a respectable minority of cases have melancholia in the first stage of paresis. In the cases of melancholia the post-cervical pain is quite marked and is not present in cases of general paresis, even when headache is severe. A fact that bears out the statement that melancholia is quite often a symptom in general paresis is the presence of suicidal tendencies in many cases. The delusions in this disease are fixed and they are in most cases about the accumulation or possession of wealth.

R. T. HOLDEN, M. D.,  
Secretary.

### Medical Progress.

**THE RADICAL CURE OF HERNIA.**—In the *American Journal of the Medical Sciences*, Stensson and Erdmann report one death in 106 operations for the radical cure of hernia. The death occurred on the tenth day. The autopsy showed acute enteritis and nephritis.

Macewen, in 98 operations, reported one death, which was due to scarlatina.

Bassini had one death after 250 operations. The fatal result was due to pneumonia which supervened after the wound was entirely healed.

Kocher (second report) records 119 operations with one death, which was caused by pulmonary embolism on the fifteenth day. Lucas Championnière reports 266 operations with two deaths—one from internal strangulation, the other from pulmonary congestion.

Kocher (third report) relates the cases of 192 patients on whom were done 220 operations without a death.

As to the recurrences, Lucas Championnière has had 17 recurrences after 275 operations, but only 141 of the patients had been seen more than two months after the operation. Kocher reports 15 recurrences after 220 operations, 174 of the patients having been seen some considerable time after operation.

Bassini has had 7 recurrences out of 149 patients seen six months after operation.

Macewen knows of but one recurrence after 98 operations.

The danger of the operation is from infection and intestinal and pulmonary complications. The principal cause of recurrence seems to be that tendency to abnormal laxity of tissue that was the original etiological factor.

Where recurrences happen the whole benefit of the operation is not lost.

The recurrent hernia comes down slowly, is small and reducible, can be easily retained by a bandage, and usually causes no pain.

\* \*

**PURE TEREBENE IN CROUPOUS PNEUMONIA.**—Dr. Alexander L. Hodgdon, in writing on the use of pure terebene in croupous pneumonia, says: I presume that many have used this drug in pneumonia, bronchitis and other affections of the air passages, but believing its beneficial action in croupous pneumonia not to be generally known, I would like to say that in cases where I have used it, the results seem to have been remarkably good. When I meet with a case of croupous pneumonia in an adult I prescribe five drops of pure terebene on a little sugar, to be taken every three hours, and to infants I have given from one-half to one drop every three hours, on sugar. Whether this drug acts solely as an expectorant, or also as a general stimulant or antiseptic, is not known, but it probably possesses all three of these actions, and, after all, we are more deeply interested in the good effects to be obtained from any drug exhibited, than from the results accruing from an investigation of its physiological action.

\* \*

**DOUBLE OVARIOTOMY DURING PREGNANCY.**—In Landau's clinic in Berlin, Mainzer (*American Journal of the Medical Sciences*) reports the case of a primipara, four months pregnant, who suffered greatly from pain in the sacral region. Upon examination a tumor was felt, not connected with the uterus, on each side of the pelvis. These were found to be ovarian and were removed without the interruption of the pregnancy, the patient going to term and being delivered of a healthy child in spontaneous labor.

MARYLAND  
**Medical Journal.**  
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BALTIMORE, APRIL 4, 1896.

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THE eleventh biennial report of the State Board of Health of Maryland which has just been issued gives evidence of more work than the public and the physicians usually give that body credit for doing.

The board has been busy in various parts of the State in investigating the origin of contagious diseases and taking measures to stamp them out. It has offered suggestions and in many cases these excellent suggestions have been heeded. The Secretary, Dr. James A. Steuart, has attempted to obtain reports from the various local boards and for that purpose he furnished postal cards printed and addressed, on which it was only necessary for the local health officers to enter the number of cases and sign their names, but very few of these physicians would take the trouble to reply. The suggestions of the Secretary are excellent and many of them should be seriously considered and indeed many reforms would have been urged had the State allowed the necessary funds for the purpose.

When it is considered that the State Board of Health in the past two years has spent less than ten thousand dollars and the Massachusetts Board from 1886 to 1895 spent three hundred thousand dollars, the difference in the character of the work in the two boards can in part be accounted for. In the proposed plan to protect the water supply the board advocates the regular inspection and patrolling of the tributaries to the water supplies. The modern method is certainly that of filtration, as done in Hamburg, Germany, Lawrence and other places in this country. In speaking of the attack of smallpox in Charles County in 1895 the Secretary gives the highest praise to a certain proprietary disinfectant which may be very efficacious but the praise of which is very much out of place in an official report. As the report is made "through the board," it is supposed that the board sanctioned this endorsement.

The Secretary has shown himself very painstaking in collecting and collating information from all parts of the State and his arrangement with Professor Penniman of the Baltimore Medical College to test weekly the drinking water of the city supply and also from any suspected district shows true progress. The work of the county officers, as well as that of Mr. Arthur Lee Browne, the very efficient inspector, of Drs. Howard and Barker the pathologists, and of Professor Penniman the chemist, cannot be too highly praised. Professor Penniman gives as the basis of his analysis the standard of pure water to which any reader may refer, and then in accord with this plan he gives the analysis of each sample of water sent him by the board. The graphic chart at the end of the report showing the condition of the water in the different water supplies is very instructive.

Of course, while this report is as thorough as might be expected with a limited appropriation, it is far behind the reports of such States as Massachusetts, Michigan and other younger States than Maryland.

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THE subject of dispensary abuse should be of more interest to the profession and the general public than it actually is. The abuse of Dispensary Abuse. dispensaries, the abuse of hospitals and many other charities, has increased until it has taken on immense propor-

tions. The political economist and sociologist should both pay more attention to a so-called charity which pauperizes and degrades a certain class of persons.

Dr. Mansfield has given the subject some study in his dispensary experience and has taken steps to do his share towards righting this wrong. The helping of persons able to pay not only does great harm to the hospitals, to the dispensaries who look to the charitably disposed inhabitants for help, but it certainly reacts on the beneficiaries who, receiving something for nothing, thus lower themselves and probably drag their friends in the same direction. As Dr. Mansfield implies, if the reports of hospitals and dispensaries show that the number of persons applying for and receiving aid is greater each year, one would naturally suppose that the pauper class is growing. That this is not strictly true, all know.

The class of persons who allow themselves to be pauperized is growing, but aside from their degradation, they are no worse off in other respects than before and can just as well pay a modest sum for medical aid as they could before they degraded themselves by applying to a public institution. Some dispensaries charge a small fee for the prescriptions, but that is hardly fair, as it puts into competition a large institution which has grants of aid from State and city and which has its staff furnished to it without charge; it puts all this in competition with the young physician who is beginning in an humble way to practice medicine and support himself. If persons with moderate incomes would economize on dress, amusements, or in other directions, and obtain their medical aid in the right way from a physician to whom they could pay a small sum and let the really deserving poor go to the dispensaries, true charity would be done and all would be happier.

To show that even the poorest do not rely on dispensaries, it is only necessary to notice that when a severe illness visits one of these humbler homes, the aid of a physician is obtained and in some way the family manages to pay him and thus secure an independence. Many poor families go to the dispensaries for slight ailments and employ the physician at their homes when the case is more serious, and many of them make a broad distinction between the "dispensary doctor" and the "real doctor," as they call him. If every

hospital and dispensary would make it a point to refuse treatment to all who could pay even a small sum and take no money from these people even for medicines, and follow the plan sketched out by Dr. Mansfield in this issue, matters would soon right themselves and those receiving free aid when they did not deserve it would soon be separated from the deserving poor and the young doctor would have a better chance of living.

\* \* \*

MUCH work has up to the present time been done on the blood, yet it is comparatively an unknown field. The *Blood of Diabetics*. various forms of anemia have often been demonstrated and in malaria the changes in the corpuscles have been pointed out.

The latest diagnostic value of blood examinations lies, according to Dr. L. Bremer of St. Louis, in the ability to detect diabetes by examining the blood. In an article in the *New York Medical Journal*, he explains his technique and gives a brief summary of conclusions. The plates accompanying this article are very beautifully executed. He claims that by a judicious mixture of eosin and methylene blue to which certain other procedures are added, a drop of blood, which, from the author's statement, must be drawn from the fourth finger of the right hand, is spread on a cover glass and the diagnosis can be quickly made.

He has seen what he calls "sugar liners" and "border liners," by which he means cases which stray over into the border of diabetes and back again before an urinary examination can detect the departure. The examination of the blood can usually fix the diagnosis long before it can be made by testing the urine. Errors may be made unless the person carrying out the test is very skillful.

The chief result of these examinations shows that the test by the blood can be made with greater certainty and more quickly than by the urine; there is a substance in the blood of diabetics which gives a peculiar reaction with the staining fluids mentioned and no other condition of the blood causes this. The substance in the blood is hardly sugar, but some product of disorganization.

This work of Dr. Bremer deserves further study and corroboration by workers well known in the field of microscopy.

**Medical Items.**

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending March 28, 1896.

Diseases.	Cases Reported	Death.
Smallpox.....		21
Pneumonia.....		33
Phthisis Pulmonalis.....		1
Measles.....	13	3
Whooping Cough.....	10	1
Pseudo-membranous Croup and Diphtheria.	4	1
Mumps.....	1	
Scarlet fever.....	11	
Varioloid.....		
Varicella.....	1	
Typhoid fever.....	2	

Mobile is having a smallpox scare.

Yellow fever is prevalent at Rio de Janeiro.

Dr. P. Hedenius of the University of Upsala has recently died.

The State Board of Health of Maryland will hold its regular meeting next Monday.

The Kentucky State Medical Society will meet at Lebanon, June 10, 11 and 12, 1896.

The University of Würzburg has conferred the honorary degree of Doctor of Medicine on Professor Roentgen.

The American Pediatric Society will hold its annual meeting at Montreal, Canada, May 25, 26 and 27, 1896.

The meeting of the American Laryngological Association will be held in Pittsburg, Pa., on May 14, 15 and 16, 1896.

The Medical Society of Pennsylvania will hold its forty-sixth annual session in Harrisburg, May 19 to 21 inclusive.

The American Association of Genito-Urinary Surgeons will hold their next meeting at Atlantic City, June 2 to 4, 1896.

The Senate of the University of Edinburgh has resolved to confer the honorary degree of LL.D. on Sir J. Russell Reynolds.

A graduate of a western medical college refused to take the oath, but this did not seem to prevent his obtaining his diploma.

The American Neurological Association will hold its twenty-second annual meeting in Philadelphia on June 3, 4 and 5, 1896.

The thirteenth annual meeting of the American Climatological Association will be held in Lakewood, N. J., May 12 and 13, 1896.

The Medical Association of Alabama will hold its annual meeting in the city of Montgomery on April 21, and will continue in session four days.

The Sixth Annual Meeting of the Association of Military Surgeons of the United States will convene in Philadelphia, Pa., May 12, 13 and 14, 1896.

The sixth annual meeting of the National Confederation of State Medical Examining and Licensing Boards will be held at Atlanta, Ga., Monday, May 4, 1896, at 10 o'clock A. M.

Plans have been completed for a new hospital for the University of Maryland. The entire Lombard Street front will be torn down and a large modern building will be erected in its place.

A correspondent writes from Rockville that the jail there is so well kept that even the measles fail to break out. It is in the same town that the police are never vaccinated, because they never catch anything.

The Health Board of St. Louis has taken up the subject of public spitting. The New York Health Department has prepared a sign to be put in all street cars forbidding spitting in the cars and the ordinance authorizes the company to put such passengers off the cars.

Dr. George S. Huntington, Professor of Anatomy in the College of Physicians and Surgeons of New York, will deliver this year's course of the Cartwright Lectures. His lectures will deal with the morphology of the intestines and a comparative study of other organs.

The University of Maryland will hold its annual commencement on Wednesday, April 15, at noon. At night the Alumni Association will hold its annual reunion and banquet. Dr. I. E. Atkinson will deliver the annual oration on "The Present Status of Therapeutics."

Governor Morton of New York has signed the new medical bill, which raises the medical student course from three to four years, and allows students who enter colleges to graduate under the rules in force when they matriculated. This law applies to all medical colleges in the State.

## WASHINGTON NOTES.

We are indebted to the Health Department for the following report for week ending March 21. Weekly mortality: Apoplexy 7, bronchitis 2, congestion of lungs 1, consumption 17, convulsions 2, diarrheal diseases 3, diphtheria 2, diseases of brain 1, diseases of heart 15, diseases of kidneys 6, malarial fevers 1, malignant growths 5, measles 6, meningitis 2, pneumonia 19, typhoid fever 1, whooping cough 1, miscellaneous 35, total, 130. There was an additional rise in the death rate last week. The deaths numbered 130, as against 121 in the preceding week. Correspondingly the death rate advanced to 24.5 from 22.8 per thousand inhabitants. The principal diseases causing this mortality were those of the lungs, brain, heart and kidneys. Nearly one-third of all the deaths were due to maladies of the lungs, of which 19 were due to pneumonia and 17 to consumption. Brain disorders caused 16 deaths, those of the heart 15 and of the kidneys 5. These results were probably due, in part at least, to the continually severe weather. The mean temperature of the week was as low as 37°, while there was a barometric mean of but 29.9, with a high mean relative humidity of 79. The zymotic diseases were represented by six deaths from measles, one from typhoid fever, two from diphtheria and one from whooping cough. Of diphtheria, eight new cases were reported, two houses were removed from quarantine and twenty-three remained in quarantine. Of scarlet fever, one new case was reported. Placards were removed from seven houses and fourteen remained still in isolation. Of the total deaths, twenty-five occurred in hospitals and eleven were certified by the coroner. Marriages reported twenty, and births returned eighty-six.

The Medical Society of the District of Columbia held its regular weekly meeting on Wednesday evening, March 25, 1896, the President, Dr. Samuel C. Busey, in the chair. Dr. Jos. Taber Johnson presented a very large fibroid of the uterus, weighing about twenty-five pounds. The doctor presented this specimen, it having been removed post-mortem, to show that the woman might have been saved, but positively refused to be operated on. Dr. Clayton read a paper, reporting a "Case of Uremia with High Temperature, Complicated by Opium Poisoning." It was discussed by

Dr. G. N. Acker. Dr. Swan M. Burnett read a paper entitled, "Formaline in Ophthalmic Practice," which brought out much discussion by Drs. Dufour, Forwood of the Soldiers' Home, T. E. McArdle, J. Ford Thompson, Jos. Taber Johnson, Stuart Muncaster, James Kerr, Crosson, Morgan, Richie and Belt. Dr. Forwood narrated some very interesting experiments of the action of formaline on sponges, claiming that it would render aseptic any sponge, even those used in the dead-house.

Dr. R. D. Boss has been appointed Assistant Sanitary Inspector at \$2.50 per day.

Friday, the 27th, was Donation Day at the Emergency Hospital. This Hospital is an excellent institution and deserves all the help it can get. About two hundred persons contributed to it. It depends very largely upon the public for its maintenance. Large paper bags were sent last week to many merchants and others, asking for help. Nearly \$200 in money and several wagon loads of articles for the table and kitchen were received. The names of the donors will be published.

## Book Reviews.

MEDICAL AND SURGICAL DISEASES OF CHILDHOOD. By J. Lewis Smith, M. D., Clinical Professor Diseases of Children, Bellevue Hospital Medical College, etc. Eighth Edition. Thoroughly revised and greatly enlarged. With 273 Illustrations and four plates. Lea Brothers & Co., New York and Philadelphia. 1896. Price \$4.50.

Dr. J. Lewis Smith's former editions have been very widely known as perhaps the best text-book on this subject for students by any American author. His teachings, plain, simple, yet based on large experience and full of conservative wisdom, have been the trusty guide of many a young practitioner through the mazes of pediatric ailments. A careful revision, bringing them fully up to the limits of recent achievements, can have but added to their value. In the present edition Dr. Smith has been aided by Dr. Frederick M. Warren, by Dr. O'Dwyer of intubation fame and by Dr. A. R. Robinson, Professor of Dermatology in the New York Polyclinic; and a large section has been added by Professor Stephen Smith, the well known surgeon, on the Surgical Diseases of Children. It is to be regretted that these

valuable improvements have led to a condensation in printing which, with the substitution of the slightly tinted glazed paper so much used at present, renders the perusal of the book much more trying to the eyes than in former editions. The student's or practitioner's eyesight is so precious, and his success in later life is so dependent upon his careful preservation of the eyesight during his whole career, that a protest ought to be entered against the policy of publishers who cheapen books by the use of too small or too close print or of paper with an unpleasant sheen. And when a book which was in former editions easy to read and pleasant to the eye comes out with an undesirable change for the worse in the above respect a protest is especially timely. Whether surgical diseases need lengthy discussion in a text-book on Diseases of Children may be left to the wisdom of the publishers.

The practitioner whose text-books on children date back ten or twenty years need hardly be reminded that the world of pediatrics has moved forward somewhat since that date, and that perhaps a later work on the subject is needed.

#### REPRINTS, ETC., RECEIVED.

Degenerative Heredity. By Charles Denissen, A. M., M. D. Reprint from the *New York Medical Journal*.

Notes on Lithium. By Enno Lander, Ph.D., Ph.G. Reprint from the *Journal*.

Anemia. By George D. Barney, M. D. Reprint from the *New York Medical Journal*.

The Technics of Maunsell's Method of Intestinal Anastomosis. By Frederick Holme Wiggin, M. D. Reprint from the *New York Medical Journal*.

Hypertrophic Rhinitis. By Edward J. Birmingham, A. M., M. D. Reprint from the *New York Medical Times*.

A New Operation for Congenital Ptosis. By T. C. Evans, M. D. Reprint from the *New York Medical Journal*.

Supplementary Report on the Success of Electrolysis in the Treatment of Urethral Strictures. By Robert Newman, M. D. Reprint from the *Journal*.

Electricity in the Treatment of Exophthalmic Goiter. By Robert Newman, M. D. Reprint from the *Journal*.

#### Current Editorial Comment.

##### DISEASE GERMS IN THE OFFICE.

*New York State Medical Reporter.*

THE busy practitioner of medicine receives in his office dozens of cases weekly of what we now recognize as infectious diseases, and yet we believe it the exception for him to see to the more thorough cleansing of the floors, wood-work and ceiling of his office, than is given other parts of his house. We have no actual facts to bear us out in the statement, yet we believe that an alarming number of virulent disease germs might be demonstrated in the furnishings of most medical offices.

##### FACIAL DIAGNOSIS.

*Charlotte Medical Journal.*

ALMOST every physician and surgeon is familiar with the part that the patient's face plays in the diagnosis of disease, the face, the eye, the attitude or movements. There are many physicians who have been observant, often come to the most important and perfectly sound conclusions about the state of his patient's heart and lungs before ever he takes out his stethoscope. What is here noticed at least makes out a *prima facia* case for examination in a certain special direction. Some men have remarkable gifts in this line of diagnosis, and all men ought to cultivate the observation of such facts. When we look back over the list of our great and best physicians we find they all have done so, and herein lay their success in a large measure.

##### RECKLESS SURGERY.

*Medical Mirror.*

THAT in these modern days of antisepsis there has been a marked tendency in every direction towards reckless surgery all will admit. It is the duty of the careful and thoughtful to now and then utter a note of warning. That the skilled artist, the giant in surgery under proper antiseptic procedures, can do things now that in former years was never dreamed of in surgical philosophy is true, and it may be safe for these shining lights to continue such work. But as teachers they should have a care when giving demonstrations of their skill and presenting the technique to their classes, that they impress the latter with the grave responsibility involved and sink deep into the hearts and brains of the individual students the thought that all that pertains to the well-being of the human life carries a terrible responsibility.

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## Original Articles.

### SOME ORTHOPEDIC CASES.

SHOWN TO THE CLINICAL SOCIETY OF MARYLAND, FEBRUARY 21, 1896.

By R. Tunstall Taylor, B. A., M. D.,

Surgeon to the Hospital for Crippled and Deformed Children, Baltimore.

#### CLUB-FEET.

I WISH to present two cases of talipes equino-varus in which Phelps' operation was done. The first is a boy, H. J., of German parentage, three years and a half old, who came to the Hospital for Crippled and Deformed Children, on October 2, 1895, no other cases of the kind being known in the family. The deformity was noticed at birth in the left foot. The mother attributed it to a jolt from a carriage. When six months old, tenotomy was done on the tendo Achillis and a plaster boot was worn for a month, after which a leather shoe was worn with a special strap which was prescribed and made by Willms.

This failed to correct the deformity, as it shortly relapsed. When first seen at my clinic, the foot was markedly inverted, could not be manually everted, or brought to a right angle, that is, dorsally flexed. The tendo Achillis was tense and the astragalus was prominent. As the child walked, the foot rolled over on its outer edge, throwing the weight on the outer aspect of the dorsum. In other words, "the ankle seemed to give way."

On October 5, I divided subcutaneously the plantar fascia and tendo Achillis on the left foot and put it up in plaster in a valgus position, with the

foot dorsi-flexed. The plaster cast which I present at this meeting was made October 4, the day before the operation.

November 21, the foot can be brought to a straight line but is not over-corrected sufficiently. It is held, however, straight by the Taylor club-foot shoe. The Phelps' operation of open incision was then done just in front of the internal malleolus to the bone, dividing the tibialis posticus, abductor pollicis and some of the plantar fascia, that still resisted, when the foot could be easily over-corrected. The wound was allowed to heal by a blood clot while held in a plaster Paris boot, which was worn a month, after which the Taylor club-foot shoe was reapplied with a result which I think you will grant is perfectly satisfactory.

The second case which I have here is R. G., a girl of 4 years; had extremely severe talipes equino-varus in the left foot. The maternal impression in this case, as the mother claimed, was "fright at a turtle bone in some soup" and the mother says "the foot caught when she started to rise from the table." This foot was operated on when the child was four weeks old; what operation was done is not known. It was held in plaster, how long is not stated. She shows an extreme degree of equino-varus in the left foot, the line of the toes being held

perpendicular to the ground. The patient stands on the outer margin and dorsum of the foot, where a bursa,  $1\frac{1}{4}$  inches in diameter, is developed. That portion of the foot anterior to the mediatarsal joint is directed upward and inward. Extreme equinus is also present. Thus it can be seen from the cast which I have here that the child practically walked on the dorsum of the foot continually. Phelps' operation was done in this case, which is one of the worst I have ever seen, and with the satisfactory result that you can see in the patient before you. This child, like the other, will wear the Taylor-club-foot shoe for a year, after which all danger of a relapse will probably be passed.

The following rules I have found can be well followed in treating club-foot :

1. In infants who have not walked on a congenital equino-varus, the deformity can be easily cured by manipulation by correcting first the varus and later the equinus and holding the foot in plaster of Paris dressing, after each manipulation, until over-correction is obtained. The child should then wear a retention apparatus for a year after it has learned to walk.

2. After a child has walked on the deformity, if manual force will not correct the deformity under ether, the Phelps operation, which consists of the following steps, should be done :

(a) Subcutaneous tenotomy of the tendo Achillis, which overcomes the equinus.

(b) If the plantar fascia on the inner aspect of the foot resists, a subcutaneous fasciotomy may cure.

(c) If skin still resists, an incision just in front of the internal malleolus should be carried down to the sole of the foot and one-third across the latter. If necessary, this incision can be carried down to the neck of the astragalus, in which case the following tissues may be cut if they offer strong resistance:

- (1) Plantar fascia.
- (2) Tendons of the tibialis posticus.
- (3) The abductor pollicis and flexor brevis.
- (4) Long flexors.
- (5) Deltoid ligament.

(6) The internal plantar arteries and nerves.

(7) Astragalo-scaphoid ligaments. If division of these fail to over-correct, which is most rarely the case in children, then—

(d) Linear osteotomy of the neck of the astragalus.

(e) If this fails also the cuneiform osteotomy of the os calcis should be done with the apex of the wedge meeting the linear osteotomy of the neck of the astragalus.

It is almost needless to say that the strictest asepsis is essential to success. A wide gaping wound is allowed to heal by blood clot organization. It is covered with rubber tissue, the dorsum, posterior and plantar aspect are well padded with gauze handkerchiefs to avoid pressure on the vessels and the foot encased in plaster of Paris dressing in an over-corrected position. In but very few cases will osteotomy be necessary. Dr. Phelps tells me in 200 cases of severe club-foot he found it necessary to perform but 20 osteotomies, *i. e.*, in about ten per cent.

"Osteotomy," says Phelps, "including astragalus resection, ought never to be performed as a primary operation, for the following reasons :

" 1. After the soft parts are divided in ninety per cent. of the cases, it will be found unnecessary.

" 2. There is a mortality of from 3 to 5 per cent. in primary osteotomy for the relief of club-foot.

" 3. Excision of the astragalus should never be done, as it shortens the leg."

" 4. From a large number of pathological specimens in his possession the contraction and deformity of the soft parts are out of all proportion to the deformity of the bone. In only two or three specimens of very severe talipes equino-varus slight deformity exists in any bone, but rather a dislocation of all bones of the tarsus and slight changes in their articular facets."

Sayre reports in the *New York Medical Journal*, December 21, 1895, the case of a man 26 years old with both feet equally deformed, representing the worst club-feet he had ever seen. In speaking

of correcting the varus, he says on the right foot he removed the astragalus and in the left he divided subcutaneously all resisting fibers of tendons, fascia, muscles, etc., and obtained a better result than he did in the right foot.

Bradford and Cushing, in the recently issued Boston Children's Hospital report, covering a period from 1869 to 1894, say on this subject :

"Excision of the astragalus was done in five cases in the belief that this would obviate the necessity of after-treatment. In one of them, however, a relapse occurred which was only corrected by an osteotomy of the os calcis. In the others the results were not as satisfactory as those which follow open incisions with or without osteotomy of the neck of the astragalus and os calcis."

In no case of club-foot can assurance be given that the foot will not relapse unless a retentive apparatus is worn from six to twelve months after correction of the deformity, then the weight of the body will tend to prevent recurrence.

#### SPASTIC PARAPLEGIA.

I next wish to show two cases of spastic paraplegia which have been under my care. The first case (A. W.) is a boy of 14 years, the third child of an American father and German mother; was brought to me January 3, 1896, for general muscular twitching and incoordination of movements. The father states these movements have been present and gotten worse in the last six years; this, however, is probably an error and the choreiform movements were present at birth or shortly after, in all probability.

The family history is good. The history of the child tells us that he was a still-birth, was plunged into ice water (which the father holds injured him permanently) before he breathed and cried out. Labor lasted "but two or three hours" and was a breech presentation. No instruments were used. The child was nursed and bottle-fed on condensed milk also. He had scarlet fever at four and measles at seven, with no serious sequelae. When two years old, the father thinks a nurse frightened the pa-

tient and increased his nervousness. He talked at two, but has never had distinct articulation. He did not show any disposition to walk until three or four years old, although braces were tried at one and a half years.

Progression has always been of the cross-legged variety and in an equinus position with the feet adducted. He could not even learn his "A. B. C.," although he went to various public and private schools up to three years ago, but since that time has progressed rapidly. At no time did he seem idiotic, but he was vicious and revengeful, "would throw things at an offender if angered." The legs and arms are said to have been rigid for the first two years of life, but were rubbed and manipulated until as supple as at present. There has been little or no improvement otherwise in the boy, according to the father, although he had been under the care of surgeons and specialists here, in Philadelphia and New York, since he was two years old, and massage, electricity, arsenic, bromides and braces have all been tried, together with division of the tendo Achillis.

On entering the hospital, the boy showed marked choreiform movements, was bright and quick apparently, had good color and was well nourished. Examination of the thorax and abdomen revealed nothing abnormal, but the incessant movement rendered auscultation most difficult and, as in acute chorea, the spasmodic movements were more marked when the patient was under observation. Pupils are slightly dilated, respond to light and accommodation, but when the eyes are closed and the patient stands, there is a tendency for him to fall to the right side. He walks with a staggering gait of a jerky variety and progression is cross-legged and in equinus. There is under observation almost incessant spasm of the facial muscles, sterno - cleido - mastoids, the deltoids, the pectorals and the muscles of the arms and forearms, thighs and legs. The adductors are held extremely rigid, so that it is difficult to separate the thighs. The gastrocnemii make the tendo Achillis tense, but the solei seem

atrophied. The plantar arches have given away and the feet are flat.

The knee jerk is present but not abnormal in the left leg, slightly subnormal in the right. There is no ankle clonus. Lying in bed the feet overlap, the right foot being uppermost.

On February 8, under ether, it was noticed that ankle clonus could be well demonstrated, especially on the right side.

The adductors were divided then just below the inguinal fold by open incision and the tendo Achillis on both sides by subcutaneous tenotomy.

At the present time, the boy walks on the flat of his feet with the legs less adducted, but the feet are very much inverted. Further operation will be done in this case to overcome this. There has been no improvement in the choreiform movements, although rest, arsenic, the antispasmodics and passive movements have been tried.

The second case (M. R.) is a girl of 12 years, whose past history it is impossible to obtain, as she was found in the Bay View Asylum and subsequently admitted to the Home for Incurables. She is an orphan and has been bed-ridden all her life; she has rather a simple expression and is poorly nourished. Her intelligence is below that of other girls of her age, but she is quick to learn if taught. Eyes are normal, save when confused there is a slight tendency to a convergent squint. Some of the teeth are defective. The thorax and abdomen are negative.

The right forearm is semi-pronated and rigid. The right arm is held abducted rigidly from 45 to 90 degrees with the body. The right hand is flexed and adducted, the second and terminal phalanges tend to extension and show characteristically the athetotic movements peculiar to this condition. The left forearm, arm and hand are but slightly rigid. The child cannot stand.

The right thigh is but slightly adducted and flexed, while the left is markedly so, the adductors being extremely rigid. The hamstrings in both legs are very tense, causing a flexion of 75 degrees. The tendon reflexes are

very active and ankle clonus is very pronounced. The skin reflexes are hyperesthetic. The calf muscles are poorly developed and the plantar arch is practically obliterated; the scaphoid and cuneiform bones are prominent and both feet are pronated and abducted, anterior to the medio-tarsal joint.

In this case, a Faradic current was applied frequently to the arms, with active manipulation and improvement was noted.

On October 9 I divided by open incision the hamstrings (internal and external) and the adductors on both sides and subcutaneously the tendo Achillis, abducted the thighs, extended the legs on the thighs, brought the feet to a right angle with the legs and enclosed the legs over the other dressings to the waist in plaster for two weeks, after which braces were made with the waist band, joints at hips and ankles. By these the child can stand erect and holding on a chair or bed, to walk, after a fashion, across the room.

The gain is but slight, but it is better than being compelled to lie on the right side continually in bed.

Starr's American Text-Book of the Diseases of Children has an excellent article on "Infantile Cerebral Palsies," by Dr. Frederick Peterson, which, together with Bradford and Lovett's and Young's Orthopedic Surgeries, I have used in preparing the following remarks:

Infantile cerebral palsies show themselves as monoplegias of the face, arm or leg, as hemiplegia or double hemiplegia, *i. e.*, diplegia or a paralysis of lower extremities (paraplegia) depending on the amount of cortex cerebri involved. We may have one arm and both legs involved, as seen in this girl.

*Historical note.*—A Frenchman, Cazanvielh, in 1827, was perhaps the earliest contributor to the study of these palsies as a separate entity. He speaks of six autopsies he made and describes a primary idiopathic agenesis and a secondary agenesis due to a variety of cerebral disorders. Henoch, in 1842, was the first German to write on this subject in *De Atrophia Cerebri*. He was followed by Little in England and Sarah McNutt

in this country. Heschl gave the name of porencephaly, or "a hole in the brain," to the condition.

Cotard found pathologically cicatrices, cysts, cell infiltration, defects and primary and secondary diffuse lobar sclerosis. In America, this literature has been much increased by Weir Mitchell, Gibney, Lovett, J. Lewis Smith, Sinkler and others.

Dr. Osler has given us one of the most valuable monographs on the subject from a clinical and pathological standpoint.

*Statistics.*—One sees about two cases of infantile paralysis to one of birth palsies.

*Sex.*—It is more common in boys than girls.

*Location.*—Hemiplegia is the commonest form, next diplegia, then paraplegia. Cerebral monoplegia is rare. The two sides are about equally often affected.

Most cases of diplegia and paraplegia are congenital, whereas many cases of hemiplegia are acquired after birth. In diplegia, usually all four extremities are affected, but occasionally only three (as in M. R.'s case). As a rule, acquired palsies appear in the first three years of life.

*Etiology and pathology* is divided by Sachs into three groups:

(1) Palsies of prenatal origin.  
(2) Palsies the result of injury during parturition.

(3) Palsies acquired after birth, etc.

Under 1, trauma, or serious diseases, as typhoid, etc., to the mother during gestation is a frequent cause of injury to the fetal cerebrum. Fright is another cause in a few cases reported. Premature birth in four or five congenital cases. Syphilis is a rare cause. Under this head we have as a pathological result:

*True Porencephaly.* (a) Large cerebral defects, such as the exposure of the island of Reil.

(b) Cerebral hemorrhage and its results.

(c) Cortical agenesis.

Under 2, tedious labor, which is more apt to cause the trouble in primi-

parae and where forceps are not used. Meningeal hemorrhage (rarely intracerebral) occurs and we have pathologically meningo-encephalitis chronica; sclerosis; cysts and atrophies (porencephalies).

Under 3, acquired paralysis about 20 per cent. come from the acute exanthemata and acute infections, notably pneumonia and whooping cough, the cough being an important factor in the causation of the palsy. Other causes are trauma to the skull, hereditary syphilis, epilepsy and infantile convulsions.

As a result, we will find, at the postmortem, meningeal hemorrhage, embolism and thrombosis, causing cysts, softening, atrophy, diffuse and lobar sclerosis, chronic meningitis and hydrocephalus. Meningeal or cerebral hemorrhage due to arterial disease is most frequently found to be a fatty degeneration in children, while in adults we have the atheromatous variety.

*Symptoms.*—Convulsions or coma usually mark the onset. Perhaps epileptic seizures may follow. Nothing further need be said as to the distribution of the paralysis. In acquired palsies in children who talk, aphasia may come on as frequently in left as in right hemiplegias.

Articulate speech is imperfect in nearly all cases. The reflexes are usually exaggerated, but vary; sometimes normal, then again subnormal or markedly increased. Rigidity may make examination of the reflexes difficult to determine.

*Athetosis.*—An inability to remain in one position for any length of time occurs in about 20 per cent. of hemiplegias and diaplegias.

*Choreiform movements* are found in five to six per cent. of hemiplegias, but more rare in diplegias.

Ataxia, rhythmical contractions, tremor, tetanoid contractions and nystagmus are occasionally found. Perhaps the most striking symptom in almost all of the cases is the rigidity of one or more of the extremities. This Weir Mitchell compares to "lead pipe," which is rigid, but can be bent by steady pres-

sure. This we see in the way a child walks in a cross-legged manner called the "scissors gait" from adductor spasm and in the various forms of paralytic club-foot, etc.

There may be some retardation in growth of paralyzed limbs. We may also have epilepsy, idiocy, imbecility or feeble-mindedness as accompaniments. Also physical defects in the development of the cranium.

*Diagnosis.*—Death from infantile apoplexy is rare, but the duration of life is short, few cases reaching the age of twenty. Some hemiplegics may live to be forty. Probability of recovery depends on the extent of the lesion. Where extensive, little can be done or hoped for. The legs in some cases may show improvement and permit a sort of uncertain locomotion. The facial paralysis may almost entirely disappear.

*Treatment.*—At birth if any cerebral lesion should be evident, quiet and sedatives should be used as in adult apoplexy. In spastic paraplegic children much good can occasionally be done by tenotomy and myotomy to correct the deformity and the subsequent application of suitable braces to prevent recontraction. As after-treatment, massage, manipulation and faradic electricity are helpful.

#### TUBERCULAR OSTEITIS OF THE HIP-JOINT.

I wish finally to show four cases of tubercular osteitis of the hip-joint and make a plea for continuous and efficient traction in this disease.

After the usual bed treatment with Buck's extension and the gradual lowering of the inclined plane, I may say, by the majority of physicians, such cases are then allowed in a month or six weeks to walk on the diseased leg without any traction splint whatever, and just so surely will relapse and deformity take place. Scarcely a case comes to

me that does not give such a history, with a badly flexed thigh, as shown by the arching of the dorso-lumbar spine if the leg is brought down on the examining table. Adduction or abduction is present also. Three of these cases on admission had a position of flexion of more than 45 degrees. In the fourth the disease was in its incipiency and no flexion had occurred. In the other cases the position of the flexion was overcome by fixation on Bradford frames and traction in the line of the deformity.

When the legs became parallel and the deformity disappeared, I applied long traction hip splints (modified Taylor's or Sayre's), put a high sole on the foot of the well leg, gave them crutches and sent them home. All of them have good motions in all directions with but little, if any, shortening, as you can see. The diseased focus at the hip-joint will thus, for two or more years, be prevented from trauma and allowed to heal, which would be impossible otherwise.

I wish to report a case of hip disease in an infant (I. U.), nine months old, with a phthisical father and phthisical grandparents on both sides. The diagnosis in this case was made certain from the complicating and fatal tubercular meningitis, which appeared later on. The child was first seen December 11, and the trouble had been noticed in the left hip for four weeks, and manifested by pain on movement, and it did not move its left leg as it did the right. Previous treatment had consisted, as is so often the case, in rubbing the joint with some liniment.

Physical examination, on first coming to the dispensary, showed that motion was limited by spasm in all directions and was painful in the left hip. A Bradford frame with extension was ordered. Temperature when first seen was 99°F.

December 19. Slightly improved motion without traction, but with recumbency and immobilization.

December 28. Little change since last visit.

January 10. Mother brings child in a very listless condition, with history of two days of persistent vomiting, due, she thinks, to cod liver oil she gave

him. Her menses returned and his illness began about the same time. Internal strabismus and marked bulging of the anterior fontanelle had been noticed by her. Also anorexia (nursing), constipation and hyperesthesia. Left hip is held stiffly. Pupils enormously dilated.

On admission, the temperature was 100° F., pulse 140. The child lies in the crib a limp mass and sleeps with eyes half open. Anterior fontanelle prominently bulged, so as to be a conspicuous elevation of the vertex. Pupils do not seem to respond to light or accommodation. Vision seems lost. No discharge from ears seen. Tongue slightly furred on dorsum. Heart, lungs and abdomen negative. Noises and light do not dis-

turb child perceptibly, nor does handling. Cries but little and then simply a whimper. Ice cap ordered for head and spine and castor oil by mouth. Fed by mouth with modified cow's milk from teaspoon, as the child could not nurse from bottle.

After two days, as the diagnosis of meningitis was well established, and the child seemed to be sinking, the mother was allowed to take the child home, where it died on January 16. No autopsy could be obtained.

Brodie, Depuis and Crocq have reported cases of hip disease at one month, three months and nine months respectively; but as a rule hip disease attacks children between the ages of two and thirteen years.

## COLLES' FRACTURE.

READ BEFORE THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.,  
FEBRUARY 18, 1896.

*By Louis K. Beatty, M. D.,*  
Washington, D. C.

FRACTURES at the lower extremity of the radius near the wrist are of a very common occurrence and the result of treatment is frequently very unsatisfactory to both patient and surgeon.

The one to which I wish to call attention is that known as Colles', from the surgeon who first described it, and of which I have a record of thirteen cases which have come under my care.

In this fracture the carpal end of the radius is broken across obliquely from before backwards from one-half to two inches from the wrist joint, causing a characteristic deformity which should be very easily recognized.

It is usually caused by a fall on the palm of the hand, or, as in the case of a school-girl, who attempted by using the palm of her hand to stop her rapid progress in the play-room, on coming in contact with the wall, saved her face at the expense of her wrist.

The diagnosis of this injury is easy or difficult according to the extent and nature, whether simple or impacted; in

both conditions the deformity is much the same, but in simple crepitus is easily gotten and makes diagnosis a very easy affair. But this fracture is much more likely to be impacted, and has many times been regarded as a sprain of the wrist in spite of the well known fact that any force sufficient to cause a dislocation of the wrist joint is more than sufficient to fracture the carpal end of the radius and also that the same force is required to cause the condition.

The evidences of this fracture vary according to their nature; when simple there is usually not so marked a deformity and tumefaction about the wrist; swelling at its dorsal side with loss of motion and of course crepitus on rotation; when the fracture is impacted the signs are very characteristic and should be looked upon as diagnostic.

There are three varieties usually seen.

1. Simple transverse.
2. Simple with comminution of the lower fragment.

3. Simple, with firm impaction of the upper into the lower fragment.

In the first class the deformity is not so marked, but the crepitus and tumefaction on the dorsal aspect, with loss of motion of the radius, make the condition clear.

In the second and third classes deformity is so characteristic as to put the condition beyond a doubt. On looking sideways at the arm held in a horizontal position the remarkable undular distortion of the wrist (commonly called the silver fork deformity) will be seen. There is considerable dorsal prominence apparently situated above the carpus and immediately under this on palmar aspect of the wrist there is a marked hollow arch confined to the radial side of the arm; just back of this, on the lower part of the anterior aspect of the forearm, there is another prominence not so distinct as that on the dorsal aspect.

The hand is adducted, rotated outwards and oblique to the forearm, the ulnar border is convex, with the styloid process projecting sharply under the skin, caused by shortening of the radial side.

Pain at the seat of injury is very severe, greatly increased by manipulation; the hand is useless; power of rotation is lost, although pronation and supination may be simulated by action from the muscles of the arm and shoulder.

The pathology of this injury and cause of the peculiar deformity has been a subject of discussion owing to the fact of one so seldom having an opportunity of dissecting a recent fracture; however, it is universally agreed that the dorsal prominence is due to the lower fragments carrying the carpus with it being displaced upwards and backwards; and the palmar prominence to the projecting forwards of the lower end of the upper fragment.

The displacement of the fragments is largely due to muscular action and the lines on which the force producing the injury have been drawn, that of the distal fragment due to the pronatores quadratus and radii teres; that of the proximal fragment is, I think, more in appearance than real, being simply caused by an oblique impaction or the drawing

backwards of the distal fragment by muscular action.

The manner in which this injury is produced is almost universally from a fall where the person instinctively throws out the hands to save the body from a worse injury.

The hand is in a semi-prone position, bringing the ulnar side of the arm first in contact with the ground, the fracturing force is directed towards the radial side as well as backwards and upwards; the hand is driven from the ulnar towards the radial side, causing the marked prominence of the styloid process of the ulnar. If the hand were in a position of complete pronation we would probably have a fracture of both bones and a somewhat different set of objective symptoms, which I do not intend to discuss at this time.

In the treatment of this fracture, our object is to replace the fragments of bone in their proper position, and retain them until bony union is complete. For this purpose several methods have been devised, all of which have given more or less satisfaction, probably more to the devisors because of the more perfect understanding of the mechanical theory involved. To my mind the understanding of the mechanical theory is of more importance than the apparatus used.

Probably the most used is the pistol splint, of which we have several varieties, the principal object of which is to correct the shortening on the radial side and reduce the prominence of the styloid process.

The straight splints, of which there are a number, such as a long external and short internal; an external and internal of the same length. One author, whose name I have forgotten, uses only a long external splint.

Many surgeons are using plaster of Paris bandages. This looks to me the least promising. I have never used it and would not like to take the responsibility of trying it. However, the apparatus used is of much less importance than the intelligent use of the one chosen.

I have always used the short straight

splints, anterior and posterior of the same length, extending from below the elbow to the first phalanges of the fingers. These should be carefully padded, the internal splint being made much thicker about the middle or at that point where it comes in contact with the prominence on the palmar aspect. The splint to be placed along the outside of the arm should have a compress placed in the padding in the anterior third or directly over the dorsal prominence.

Extension and counter-extension should be made until the fragments are in perfect position before the splints are applied.

Where the bones are impacted this requires considerable force. The force should be continued until the dorsal prominence has entirely disappeared. In very muscular subjects or cases of strong impaction, it is much better to use an anesthetic. In the case of a very muscular subject who came under my care in the district jail some years ago with this injury, I do not think it would have been possible to have secured anything like a reduction of the fracture without the use of an anesthetic.

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**IMPORTANCE OF FREQUENTLY WEIGHING PULMONARY INVALIDS.** — When treating pulmonary consumptives, says the *New York State Medical Reporter*, do not fail to keep a careful and systematic record of their weight. The weight of such patients is in reality a thermometer of their condition. The correct weight indicates more certainly than any other sign or symptom the return of health or the approach of physical dissolution. The weight should be as carefully watched and recorded as the pulse and temperature. It should not be taken every week or every month, but should be recorded every day and as nearly as possible at a certain hour each day. The ordinary pulmonary consumptive weighs from one to two pounds more after dinner than after breakfast, and this fact must always be taken into consideration when computing the average weight. A reliable pair of scales

The splints should never be allowed to remain more than five or six days at the beginning of treatment and after that not more than three days at any one time.

It has always been my practice to remove all dressings on the fifth day, and examine the condition of the arm, using massage and slight passive motion. After that I remove the splints and use massage and passive motion every second day until union is complete, which is from four to five weeks, according to the age of the patient. In this way I have been able to get results which have been very satisfactory to myself and I think to my patients. I do not intend to recapitulate my cases at this time. I have attended thirteen only during my years of practice and have not had one case of stiff or deformed joint.

In one case, that of a young boy living in the block with my office, the patient sustained a fracture of both wrists at the same time, from a fall from the top of the house to the ground, a distance of about twenty-five or thirty feet. His recovery was complete from this and other injuries sustained at the time.

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should, in every instance, constitute a part of the doctor's office furniture. The ordinary practice of weighing upon grocery scales and usually upon different scales on each occasion, or on "drop a cent in the slot," cannot be depended upon in the least. Extra clothing, overshoes, etc., must also be considered in taking the weight.

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**MYOMA OF THE RECTUM SIMULATING OVARIAN CYST.** — Westermark (*American Journal of the Medical Sciences*) reports a case of tumor of the rectum which was diagnosed as ovarian cyst, the error not being discovered before operation. The patient died of ileus, due to intrapelvic adhesions of the intestines, which the writer attributes to the use of the gauze drain. Similar errors in diagnosis were reported by Senn and Berg.

## Society Reports.

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### CLINICAL SOCIETY OF MARYLAND.

MEETING HELD FEBRUARY 21, 1896.

THE 319th regular meeting of the Clinical Society of Maryland was called to order by the President, Dr. J. M. Hundley.

Minutes of the last meeting read and approved.

*Dr. R. Tunstall Taylor* read a paper on ORTHOPEDIC CASES, with exhibition of patients. (See page 451.)

*Dr. Randolph Winslow:* The cases of club-foot reported by Dr. Taylor interested me particularly, because in former years I did a great deal of work in that direction. I believe that most cases occurring in young children can be treated without operative procedure, but if the trouble has existed for some years it becomes necessary to do an operation of the cutting character. In the young child the ligaments are pliable and soft, and the position of the bones can be changed, but in the course of time the bony surfaces alter, the ligaments and the tissues also become shortened so that treatment that would have been appropriate in early life in a short time becomes insufficient. This operation of Dr. Phelps' is a very valuable one. In recent years the operation for the removal of the astragalus has come into vogue, but for what reason I cannot see, for it shortens and mutilates the leg. I have never removed the astragalus for a trouble of this kind. It seems to me that a cuneiform resection of the process is better than an excision of the astragalus. When you do the first, the articular surfaces of the ankle are not interfered with, but where you remove the astragalus you bring the tibia and fibula in connection with the os calcis, to which they do not correspond sufficiently well to perform the functions of the ankle joint even moderately well. The allusion which Dr. Taylor made to the report of Dr. Sayre is, I think, hardly accurate. In the first case he removed the astragalus and found that the foot could still not be

brought up to a right angle. In the second case he concluded not to remove it, but by Phelps' operation to bring the foot to a straighter position, but the equinus did not yield. This was cured later, however, by the excision of the wedge below the joint. He was more favorably impressed by the cure without removal of the astragalus than that in the case with the removal. Dr. Taylor is to be congratulated on his cases and on having such an opportunity to treat them so well.

*Dr. R. T. Taylor:* I may have read the article of Dr. Sayre too hurriedly, as I had but a limited time to prepare the paper. It is astonishing how much can be done in these cases simply by division of the soft parts.

*Dr. H. J. Berkley* read a paper on BRAIN LESIONS IN ACUTE EXPERIMENTAL ALCOHOLISM.

H. O. REIK, M. D.,  
Secretary.

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### THE CLINICO-PATHOLOGICAL SOCIETY OF WASHINGTON, D. C.

MEETING HELD FEBRUARY 18, 1895.

At the meeting of the Clinico-Pathological Society of Washington, D. C., held February 18, 1895, at the office of Dr. Holden, the paper of the evening was read by Dr. Beatty. Title, "COLLES' FRACTURE." (See page 457).

*Dr. Tompkins*, in opening the discussion, said that the diagnosis of Colles' fracture was usually easy. The main indications in the treatment were to restore the bone to its natural position, retain it there and use all known means to prevent stiffness of the fingers and the wrist after the fracture is healed. The prevention of deformity resulting from displacement of the styloid process is very important.

Flat splints seem to him to be the best, as it is so important to change the dressing and use massage; the simpler the splints the better. Besides massage, the galvanic current is the next agent in value, one pole applied above and one below the fracture. This proves a remarkably effective remedy in cases of

stiffening of the joint after carelessly treated Colles' fracture.

*Dr. Van Rensselaer* differed with the essayist in one or two of his statements. The first is the frequency of crepitus found in this fracture. His experience taught him that it was rarely present. This fact is due to the character of the tissue at the end of the bone, or in cases where over-riding of fragments takes place.

No fracture demands more attention and care than Colles'. The most important thing is to be sure we have the displacement of the bone properly reduced, and then be sure to keep it so. An anesthetic should be used in every case of Colles' fracture, and if swelling is not extensive it will not be difficult to diagnose it. In some cases it is almost impossible to say whether it is a fracture or a sprain, but it is best to treat the injury as a fracture.

Splints should be removed frequently and we should see that the fragments are in proper position. For this reason plaster bandages are not the best. Flat splints are the best; he usually uses a short dorsal splint and a long anterior or palmar splint and retains them in position by adhesive straps. It is well to remove the splints in four or five days and begin passive motion and manipulation of the fingers.

In four weeks in adults and three weeks in children the splints can be dispensed with. It is not well to use heavy material for splints. Two or three years ago a surgeon of Rochester, New York, advocated a band of adhesive plaster around the wrist as sufficient to retain the fracture in position.

*Dr. Sprigg* did not think it was always necessary to use an anesthetic in Colles' fracture. Where the injury has existed for six or eight hours, it should be used. There is no fracture causing as much trouble as improperly treated Colles' fracture. Adhesions form, destroying the use of the joint by immobility. Perfect reduction and retention in proper place of the fragments are the indications.

Letting the hand fall somewhat so that the weight of the hand causes some

extension and thus assists in keeping the fragments in place is a favorite way in dressing this fracture. From three to five days is a proper time to allow the dressing to remain after the first treatment.

*Dr. Beatty*, in closing the discussion, said as to crepitus being found in this fracture, he cannot remember more than one out of the thirteen cases reported in which it was present. Plaster of Paris bandages are used by some surgeons in Washington; he saw a case a few days since of a boy who had fallen and sustained a Colles' fracture in both arms; a plaster dressing was used and ankylosis of both wrists exists. The most approved method of fastening the splints is by the use of adhesive straps. An anesthetic should be used in nearly every case, particularly in impacted cases and in very muscular subjects. Massage, passive motion and frequent inspection of the injury are the indications.

R. T. HOLDEN, M. D., Secretary.

### Correspondence.

#### AN OBSCURE CASE.

Editor MARYLAND MEDICAL JOURNAL:

Dear Sir:—I enclose a letter just received and hope you may find some use for it. It is too good for the waste basket and I should like to know which tube it is in and what treatment you would advise. It seems a good case for the Roentgen ray. Yours truly,

G. A. FLEMING, M. D.

MACH 27th 1896.

DR. FLEMINGS.

dear Sir

I Just arrive Home a few days ago & I was Eating some Catfish Wednesday & a bone Slip down The Rong Pipe not my wind pipe noah The tube That Carry my food down but There is one on Each side of the main pipe & it slip down The one on The Right side I dont Think It is stuck because It moves about I Think. & last night It made me feel very badly I Think If It Had of gone down with The food It would of Past of with The food so now please to let me no what to do for It at once please.

## Medical Progress.

**SCIENTIFIC COOKERY.**—We are inclined to think, says the *Medical Record*, that the medical profession owes something to the city of Philadelphia, on account of its producing a particularly enlightened and progressive student of the noble art of cookery in the person of Mrs. Rorer. This lady has published cook-books which, we are informed, are trustworthy, and has contributed to periodicals, teaching those housewives and cooks who are humble enough to be willing to learn the sane and rational methods of cooking and presenting food. Mrs. Rorer also has time to lecture and instruct in the different cities of this country, and, while we are not quite sure that all the lady says will be accepted by sanitarians and professional hygienists, yet she undoubtedly throws off some sparks of wisdom which ought to illumine wide areas in this dyspeptic country. Potatoes, as we understand Mrs. Rorer, are little better than poison if eaten in any excess. One potato a day seems to be the Rorer limit. Medical experience, in a measure, confirms the fact that the potato is not the best type of vegetable for brain workers—at least, for the neurotic type of individual—though it does well enough for those who work outdoors all day. To eat pickles is to show a lack of education, according to the Rorer gospel. To eat them in this country rather shows that the person is in a stage of adolescence, or is suffering from certain hysterical tendencies. Pickles and candy seem to be the two things to which the nervous activity of maturing young people naturally tend. To eat them shows rather a lack of balance than of training. Cooked apples are more easily digested, but not so good for the health, says the lady. The sugar in fruit is digestible, but the sugar of commerce is an abomination. Oatmeal is a valuable food if cooked for three hours and well masticated, and all starchy food must be cooked for hours. These are truths which medical experience abundantly corroborates. Dr. McCall Anderson, for example, states that oatmeal, which

causes eruptions and pruritus in some people, can be eaten without any unpleasant results if it is cooked for three or four hours. Cabbage and onions meet approval, provided they are cooked so that they have no odor. When there is odor they are ruined for food. And the art of cooking them without odor consists in keeping them in water that is just below the boiling-point. Mrs. Rorer seems to think that Welsh rarebits are better and more digestible than bread and butter, and she herself eats one every day for lunch.

\* \*

**TUBERCULOUS PERITONITIS.**—Mazzoni reported in the *Journal* thirty-five cases of this disease treated with laparotomy, followed by recovery in thirty-three. Two cases required a second operation in eight to ten months. He merely opens the abdominal cavity and empties it of fluid. The second operation was of special interest on account of what was found in the abdomen: The tubercles had almost disappeared, around those that were left there was an inflammatory exudation, and inside there was cystic degeneration. This report was made before the Congress of Surgery at Rome, last fall, and led to a lively discussion whether all forms of peritoneal tuberculosis indicated an operation, whether the simple opening of the abdomen is enough, or whether in the peritoneum a certain amount of irritation should be produced. The members agreed to take note of all cases and compare experiences.

\* \*

**THE PREVENTIVE TREATMENT OF INFLAMED BREAST.**—Brindeau (*British Medical Journal*) points out that galactophoritis plays a great part in the causation of mammary abscess. The inflamed breast may have been infected through the blood or through the lymphatics, but most frequently the poison reaches the gland through its excretory ducts. Mammary abscess is the homologue of the abscesses in surgical kidney infected through the ureter. In galactophoritis the *staphylococcus albus* and *aureus* are found, but both species exist in healthy mammary ducts. Infection

reaches through excoriations of the nipple, through the hand of patient, nurse, or doctor, fouled with the lochia, or, most frequently, direct from the child, as its mouth is full of microbes and coryza, or more severe infantile disorders render its saliva septic. There is also, not unfrequently, inflammation of the child's fingers, at the roots of its nails. About the second week the symptoms appear—the well known earlier signs of inflamed breast. On pressure of the nipple milk exudes from some of the ducts, but pus from others. The pus is, of course, yellower and more tenacious than the milk, but suspected exudations of this kind should be tested by absorbent wool, which takes up the largest drop of milk immediately, but cannot absorb pus. That fluid, when expressed from the duct, lies on the surface of the wool in the form of a greenish-yellow drop. Sometimes a drachm or more can be expressed. The process should be repeated twice or thrice daily, and the nipple carefully washed afterwards with an antiseptic solution. The child must not be fed from the inflamed nipple. If the expression of the pus be neglected abscess will follow. Suckling from an inflamed nipple does great harm to the infant. Gastro-enteritis, pemphigus and conjunctivitis are undoubtedly caused by the ingestion of pus with milk. On the other hand, Brindeau insists that purulent conjunctivitis in infants is a direct cause of infection of the mother's mammary ducts.

\* \* \*

THE TREATMENT OF ERYSIPELAS WITH APPLICATIONS OF VASELIN.—Koster (*Medical News*) has made a comparative study of the results of treatment in a large number of cases of erysipelas, in which various methods were employed, including painting with tincture of iodine, spraying with mercuric chloride, and applications of ichthyol and of simple vaseline, and found that the results with the last were quite as good as those with any other measure, as regards mortality, complications and extension. The applications of vaseline were made twice daily and covered by gauze with a certain amount of compression.

POLYMYOSITIS ACUTA.—Dr. James B. Herrick reports in the *American Journal of the Medical Sciences* a case of polymyositis, probably of syphilitic origin (*myositis syphilitica*), from which he draws the following conclusions:

1. There is a definite disease primarily affecting many muscles of the human body and described as polymyositis acuta, pseudo-trichinosis, or dermatomyositis.
2. Inflammatory swelling of muscles, exanthem, splenic tumor, extension to the muscles of deglutition and of respiration, death, characterize the most typical cases.
3. Atypical and milder cases indicate that either the disease may run a benign course or that in the absence of definite means of differential diagnosis forms etiologically differing are confused.
4. Trichinosis and polyneuritis must always be excluded.
5. Syphilis may attack many muscles and, resembling acute polymyositis, must be excluded.
6. The etiology is still unknown.
7. Three hypotheses can be advanced as to its cause: 1. That it is due to a specific micro-organism (vegetable parasite). 2. That it is due to a chemical poison (toxine). 3. That it is due to an animal parasite (gregarina).
8. In doubtful cases the excised piece of muscle should be examined not alone for trichinae and bacteria, but as well, by special methods, for protozoa.
9. Failure to find trichinae in all areas showing inflammatory reaction, or even in the majority of such areas, does not exclude trichinosis as the primary cause of the myositis. Only repeated failure to find trichinae after thorough examination enables one positively to assert that the case is not one of trichinosis. (Compare examination of sputum or tissue for tubercle bacilli.)
10. Syphilitic myositis occurs in three forms—the gummosus, the diffuse, the combined.
11. The diffuse syphilitic myositis is usually a late manifestation of syphilis; appears without definite exciting cause; affects no particular muscle by preference; often involves more than one muscle; may resemble acute polymyositis.

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BALTIMORE, APRIL 11, 1896.

THE old saying "when doctors disagree, who shall decide" shows that the occasional variance of opinions on the *Heat and Cold in Pneumonia*. part of physicians is no secret to the people. This disagreement is usually based on an experience which may be too narrow or which brings results that would have followed any other method of treatment.

Dr. Thomas J. Mays, who is so prolific in his writing on diseases of the chest, is a warm advocate of the ice pack to the chest in acute pneumonia, while many others, and more recently among them Dr. Charles W. Ingraham, thinks the application of ice bags to the chest of a pneumonia patient little less than a barbarity, and in the *New York Medical Journal* he shows why he prefers the application of heat.

His first point is that public opinion is against the ice treatment; and let a patient once die under this treatment and the doctor will be censured far and wide. Dr. Ingraham had found the application of heat by the poultice and other ordinary methods so

troublesome that he has devised a pneumonia jacket which he has already brought before the profession.

It is a Canton flannel jacket and in it are coils of rubber tubing so fitted as to cover the whole chest and extend half way to the spine behind. The body is covered with raw cotton, which helps the patient to stand the heat better and retards radiation. The end of the coils of tubes is connected with a reservoir which is kept at a constant temperature by means of an alcohol lamp. This is a very simple and easy way of applying heat to the whole chest without the disagreeable and inconvenient poultices, and the constant flow of freshly heated water keeps up a constant warmth which the change of poultices could not do.

The advantages of the application are, in the author's opinion, as follows:

1. It hastens the various stages of the pneumonic process.
2. The high degree of heat not only hastens the disease processes, but *sustains the vitality* of the consolidated lobes.
3. It effectually prevents further extension of the pneumonic process.
4. It sustains lobular vitality, and consequently the lobe will not be so prone to chronic disease or to recurrent attacks of pneumonia.
5. It prevents complications.

\* \* \*

WITH the development of the specialty of pediatrics and its more accurate description and definition of disease processes in children has come in *Typhoid Fever in Children*. the revelation of many conditions which were wholly overlooked by physicians of former times. Without doubt many important discoveries in regard to well known or rare diseases await the closer studies of shrewd observers in this comparatively new field.

The question how frequent is typhoid fever in early childhood — say before the fifth year — has of late excited considerable interest. Older writers thought the disease was very rare under this age. Later investigations show that it is frequent, but so mild that the diagnosis is usually missed. Reports of epidemics including children under this age are therefore heartily welcomed.

In the *Boston Medical and Surgical Journal*, February 27, 1896, Dr. J. L. Morse gives

a careful review of 284 cases of enteric fever occurring in patients under fifteen years at the Boston City Hospital. The cases run from 1882 to 1895. Dr. Morse's series is compared with various others of typhoid in children given by Henoch, Wolberg, Osler, Baginsky, Schavoir, Stork, Earle, Forchheimer and others. They all agree closely in their main points, so that enteric fever in children above two years may be considered now as definitely understood. Below two years of age there is still an unknown field for research. It is a question whether the disease has yet been correctly diagnosed during this period.

Dr. Morse's deductions from his review of these cases occurring between two and fifteen years of age are very instructive. The disease occurs about as often between five and ten years as between ten and fifteen years. The mortality under fifteen is half as great as in adults. Epistaxis occurs at the outset in half the cases, often severely. The average duration of fever is three weeks, and less in the younger patients, but relapses are frequent. The remittent fever of the later weeks (associated with ulceration) is absent in more than half the patients under ten years, as might be expected from the slightness of the intestinal lesions. In young children ulceration or sloughing rarely occurs. Hemorrhage is very rare under ten years, but fatal in half the cases in which it occurs. Perforation is extremely uncommon. Rose-spots are found in from sixty to seventy per cent. of all cases. The spleen is usually enlarged, but does not always then come below the rib-border. The tongue is not typically dry and brown as in adults. Constipation is more common than diarrhea, especially in smaller children. Slight tenderness of the abdomen on pressure is found in half the cases, rarely extreme tenderness.

Bronchitis, shown by rales, occurs in about forty per cent. of cases. More severe disease of the lung is rare. Serious kidney complications are rare, especially in the very young. Neuritis occurs, but is often overlooked. Crying out at night is common, particularly in younger patients. Headache is frequent. In twenty-five per cent. grave nervous symptoms are manifested, usually stupor, but sometimes active delirium.

Enteric fever in children is often diagnosed bronchitis. The existing epidemic, the head-

ache, the rose-spots, the digestive symptoms, point to typhoid. Bacteriological conditions and treatment receive no notice in the paper.

\*\*\*

TO SUPPORT the lung in phthisis may be very well, but the first idea in the treatment of the disease is to employ expansion. Dr. Stuart Tidey in *Strapping the Chest in Phthisis* gives in the *British Medical Journal* his reasons for supporting the lung by strapping the chest in cases of phthisis.

The diseased lung is contracted and hence strapping contracts the thorax and supports the lung, and it is given a comparative rest. The fact that a pleuritic effusion frequently leads to amelioration of the lung affection in phthisis, and the fact that during pregnancy the course of phthisis is often temporarily arrested, have both suggested to Dr. Tidey to imitate nature by strapping the chest. The following are the advantages of this method:

1. In early phthisis (catarrhal stage) to give comparative rest and relaxation to affected lung tissue.
2. In the stage of consolidation, to secure the same results, thereby limiting the risk of extension, and to promote elimination of the disease products by improving the circulation in and about the diseased area, and to facilitate expectoration.
3. In the stage of cavitation, to promote closing of cavities by directing healthy lung to encroach on the diseased area instead of relying on natural processes of cicatrization.
4. Diminished tendency to hemorrhage by reduced tension on vessels and cicatricial traction on vessel walls.
5. The ultimate object is to obtain a smaller thoracic cavity filled with healthy lung instead of an enlarged thoracic cavity partly filled with diseased lung.

\*\*\*

MR. LOUIS DIETERICH has just completed a very exact and speaking likeness of Dr. H. P. C. Wilson, while Mr. *Two Portraits*. Thomas C. Corner has put on canvas a most faithful reproduction of Dr. Miltenberger in the act of writing a prescription. These two Baltimore physicians who have for years been lights in the profession will at the next meeting of the Faculty on the 28th of this month present their respective portraits to the Faculty.

Medical Items.

We are indebted to the Health Department of Baltimore for the following statement of cases and deaths reported for the week ending April 4, 1896.

Diseases.	Cases Reported	Death.
Smallpox.....		
Pneumonia.....		26
Phthisis Pulmonalis.....		21
Measles.....	7	1
Whooping Cough.....	1	3
Pseudo-membranous {	6	5
Croup and Diphtheria. }		
Mumps.....	5	
Scarlet fever.....	6	2
Varioloid.....		
Varicella.....		
Typhoid fever.....	2	1

The programme committee of the Medical and Chirurgical Faculty of Maryland is desirous of receiving papers for the meeting which takes place April 28 to May 1. Titles should be sent at once to Dr. Hiram Woods, chairman of the committee, 816 Park Avenue, Baltimore. The oration will be given by Dr. Solis-Cohen of Philadelphia; subject, "The Path and Progress in Modern Therapeutics."

At a meeting of the Trustees of the Johns Hopkins University, held last Monday, the appointments of Baltimore physicians were made, to take effect during the fourth year of instruction of the Johns Hopkins Medical School, which will begin next October. Dr. Samuel Theobald, clinical professor of ophthalmology and otology; Dr. John N. Mackenzie, clinical professor of laryngology; Dr. William D. Booker, clinical professor of diseases of children; Dr. Henry M. Thomas, clinical professor of diseases of the nervous system; Drs. J. William Lord and Thomas C. Gilchrist, associates in dermatology; Dr. Robert L. Randolph, associate in ophthalmology and otology; Dr. Henry J. Berkley, associate in psychiatry.

The following additions have been made to the Medical and Chirurgical Library since January 1, 1896:

Obstetric Surgery, Grandin & Jarman, 1895. Archives of Laryngology, Vol. 1, 2, 3, 4, 1895. Maryland Medical Journal, 1895. Journal American Medical Association, 1895, 1896. Fowler on Appendicitis, 1894. Transactions of Sydenham Society, 1895. Anatomical Plates, Quain & Wilson. Donated by Dr. Wm. Osler. Practice of Medicine, Wm. Osler, M. D., 1895. Lecture on the Diagnosis of Abdominal Tumors, Dr. Wm Osler, 1895. Text-Book upon the Pathogenic Bacteria, McFarland, 1896. Donated by Dr. Oscar H. Allis:

The Hip, Allis, 1896. Donated Dr. E. F. Cordell: Personal Reminiscences, Dr. Samuel C. Busey, 1895. Presented by Dr. Wm. H. Welch: The Treatment of Diphtheria by Antitoxin, 1895. Presented by Dr. Wm. B. Canfield, 14 Vols.: Surgical Pathology and Therapeutics, Warren, 1895. Art of Massage, Kellogg, 1895. Bandaging, Leonard, 1895. Diabetes, Dr. Emil Schnée, 1895. Manual of Surgical Asepsis, Beck, 1895. Modern Materia Medica, Roth, 1895. Railway Surgery, Dr. C. B. Stemen, 1895. Practical Urinalysis and Urinary Diagnosis, Purdy, 1895. Macrobiotic, or Our Diseases and Our Remedies, Julius Hensel, 1895. Practical Examination of Urine, Tyson, 1895. Antiseptics and Antiseptics, Buchanan, 1895. Intestinal Surgery, Senn, 1895. Presented by The Book and Journal Club of Medical and Chirurgical Faculty, organized 1896: Physiological Papers, H. Newell Martin, 1895. Treatise on Hygiene, Stevenson & Murphy, 3 Vols. 1895. Diseases of Brain and Spinal Cord, Macewen, 1893. System of Diseases of Ear, Nose and Throat, Burnett, 1896, 2 Vols. A System of Legal Medicine, 2 Vols. Allen McLane Hamilton and others, 1895. An American Text-Book of Diseases of Children, Starr, 1895. Pediatrics, Rotch, 1896. Nervous Diseases, American Authors, 1895. Diseases of the Skin, Crocker. Diseases of Skin, Kaposi, 1895. Human Embryology, Minot, 1892. A Manual of Diseases of the Ear, Albert H. Buck, 1895. The Senile Heart, George William Balfour, 1894. Toxic Amblyopias, Dr. G. E. de Schweinitz. Text-Book of Pathology, 3 Vols., D. J. Hamilton, 1894. Therapeutics of Infancy and Childhood, Jacobi, 1896. Diseases of Children, Smith, 1896. Nervous Diseases of Children, Sachs, 1895. Moullin's Treatise on Surgery, Hamilton, 1895. Tuberculous Diseases of Bones and Joints, Cheyne, 1895. Tillmann's Principles of Surgery and Surgical Pathology, Rogers, 1894. Text-Book of Abdominal Surgery, Keith, 1894. Tumors, Innocent and Malignant, Sutton, 1893. Pathology and Surgical Treatment of Tumors, Senn, 1895. The Eye in General Diseases, Kries, 1895. Hospital Construction, Galton, 1893. Atlas of Nerve Cells, M. Allen Starr, 1896. Atlas of Head Sections, Macewen, 1893. The Science and Art of Midwifery, Lusk, 1895. Diseases of the Stomach, Sidney Martin, 1895. Epidemic Ophthalmia, Stephenson, 1896. Krankheiten des Darmes, Dr. Th. Rosenheim, 1893. Diagnostik und Therapie der Magen-Krankheiten, 2 Vols. Dr. I. Boas, 1895. Histopathologie der Hautkrankheiten, P. G. Unna, 1894. Krankheiten der Eileiter, Martin, 1895. Ergebnisse der Allgemeinen, Pathologischen Morphologie und Physiologie des Menschen und der Tiere, 2 Vols., Lubarsch Ostertag, 1896. Lehrbuch der Speciellen Chirurgie, 3 Vols., Koenig, 1893-1894. Transactions of the New York Academy of Medicine, 1894. Manual of Operative Surgery, Frederick Treves, 1892. System of Surgery, 3 Vols., Dennis, 1895.

## WASHINGTON NOTES.

The weekly report from the Health Office for week ending March 28 is as follows: Apoplexy 9, bronchitis 5, congestion of lungs 1, consumption 13, convulsions 2, croup 1, diphtheria 1, diseases of the brain 5, diseases of heart 12, diseases of kidneys 7, malarial fevers 2, malignant growths 1, measles 6, pneumonia 10, scarlet fever 1, suicides 1, miscellaneous 34, la grippe 4, total 115. The mortality in the District decreased during the past week, as compared with that of the preceding week. The deaths numbered 115, while in the preceding week they amounted to 130. The death rate fell from 24.5 to 21.7. In the corresponding period of last year the death rate was 22.8. A general review of the health conditions shows a continuance of the comparatively high rate of fatal cases of brain and heart diseases, and a decline in the fatal cases of lung and kidney affections. The meteorological conditions which prevailed during the week in this connection are noticeable for severity of weather, accompanied by extreme changes. The highest temperature of the air was 66° on the 26th, and the lowest was 18° on the 24th, showing a difference in that time of 48°. The relative humidity was high and the mean temperature as low as 39°, with a maximum velocity of wind of 36 miles per hour. The deaths from lung diseases were 29, as against 39 by the last report; of these, 10 were from pneumonia, a decrease of 9, and 13 from consumption, a decrease of 4. The prevalence of measles still continues, there having been 5 fatal cases reported. One death resulted from diphtheria and 1 from scarlet fever. The number of new cases of diphtheria reported was 3. Houses released from quarantine were 8, while 18 remained placarded at the close of the week. Of scarlet fever, 5 new cases were reported, 4 houses were released from quarantine, and 15 houses remained in quarantine. Of the total deaths, 23 occurred in hospitals and other public institutions and 7 were certified by the coroner.

There was an entertainment for the benefit of the Children's Hospital on Tuesday, March 31, which was a very successful affair. A number of well known actors and actresses took part.

The Medical Society of the District of Columbia held its regular meeting on Wednes-

day evening, the President, Dr. Samuel C. Busey, in the chair. The question of the publication of the transactions was fully discussed and it was decided to publish them, but not decided where. Dr. A. F. A. King read an interesting paper on "The Propagation and Prevention of Malarial Fevers." The following persons were elected members of the Society: Dr. Charles H. Bowen, Columbian University, 1862; Dr. Randolph B. Carmichael, Jefferson Medical College, Philadelphia, 1889; Dr. Edwin Gladmon, National University, 1890; Dr. Charles W. Keyes, Howard University, 1890; Dr. Charles C. Morberry, Georgetown University, 1893; Dr. Edward E. Morse, Columbian University, 1892; Dr. J. R. Nevitt, Columbian University, 1892; Dr. Rupert Norton, Harvard University, 1893; Dr. Sofie A. Nordhoff, Columbian University, 1893; Dr. Fred. O. Roman, National University, 1894; Dr. Ada R. Thomas, Women's Medical College, Philadelphia, 1893; Dr. C. A. Weaver, Jefferson Medical College, Philadelphia, 1892.

The Washington Obstetrical and Gynecological Society held its regular meeting on Friday, April 3, Vice-President, Dr. Samuel S. Adams, in the chair. Dr. J. W. Bovée presented two splendid specimens, first a paraovarian cyst, removed by abdominal section. The woman had suffered from repeated hemorrhages. Second, a very large uterine fibroid, removed by abdominal hysterectomy, showing a large pus cavity and a submucous fibroid. Dr. W. M. Sprigg read a paper entitled, "Pregnancy Complicated with Intestinal Obstruction followed by Accidental Hemorrhage and Miscarriage." It was discussed by Drs. T. C. Smith, M. F. Cuthbert, J. W. Bovée and E. L. Tompkins. Dr. Francis S. Nash reported a case of Post-partum Nausea. Discussed by Dr. J. F. Scott. The Society then adjourned.

## Book Reviews.

INFANTILE MORTALITY DURING CHILDBIRTH AND ITS PREVENTION. By A. Brothers, B. S., M. D., Visiting Gynecologist to Beth Israel Hospital, New York, etc. The William F. Jenks prize essay of the College of Physicians of Philadelphia. P. Blakiston, Son & Co., Philadelphia. 1896. Price \$1.50.

In early years of practice the physician does not care about anything provided he gets the mother (and the old man) through all right.

In maturer years that dead baby begins to worry him, and he wonders why it died and whether he could by any means have saved it for the mother, who perhaps may have remained childless and cheerless to old age.

It is a matter of surprise that the enterprising American mind has never planned a book exclusively on this subject before. It was left to a gynecologist, of course, to do the work. Being debarred by public opinion of the profession from indiscriminate castration of women and splitting cervixes on every hand, as was once the fad, the author having had large experience in midwifery and pediatrics, spied this almost virgin field and devoted himself to its development in a way which must win him the applause and the gratitude of the profession. He considers carefully the influence of constitutional and organ-disease of the mother before labor; of local uterine diseases, of malformations, of perversions in the natural processes of delivery and of accidental complications on the part of the mother during labor. He proceeds to discuss fetal diseases in utero, multiple pregnancy, intra-uterine accidents to the fetus, faulty presentations, prolapse and errors in length of cord, excessive development of fetus. Next, the causes of death after delivery are taken up— asphyxia, immaturity, injuries to child, hemorrhages, sepsis, trismus, epidemic hematuria, etc. The result of his labors is presented to us by the publishers in clear type extremely pleasant to the eye. The volume is not illustrated (that is not necessary in order that its sense may be "understood"). Monographs such as this are among the few books which it pays the general practitioner of years' standing to buy, and its possession may enable the beginner to save lives which he would otherwise lose.

#### REPRINTS, ETC., RECEIVED.

Pelvic Inflammation. By J. W. Long, M. D. Reprint from the *Virginia Medical Monthly*.

The Etiology and Symptomatology of Pruritus Ani. By Lewis H. Adler, Jr., M. D. Reprint from the *Philadelphia Polyclinic*.

Fourth Biennial Report of the Visitors of the Maryland Asylum and Training School for Feeble-Minded at Owing's Mills, Baltimore County, to the Governor of Maryland. L. Gibbons Smart, M. D., Superintendent.

#### Current Editorial Comment.

##### SPECIALTIES.

*Canadian Practitioner.*

IN the present age of rapid advancement in medical science, it is practically impossible for any one man to keep abreast of the times in all branches of the profession, and specialties are therefore a necessity. Yet it is a most difficult task to delimit any specialty too strictly.

##### DOCTORS AND SHORT-HAND WRITING.

*Medical Mirror.*

WE have long been of the opinion that every medical student should be urged to become a master in stenography. The knowledge would enable him to take exact notes of lectures, not only during student life but later on. It would help him to be a closer listener, a good recorder and teach him how to sift out the crystals of thought from the chaff of other matter.

##### DANGERS OF SURGICAL TRIUMPHS.

*Langsdale's Lancet.*

WE are all proud of the glorious achievements in the field of medicine and surgery. The triumph of abdominal and brain surgery are victories greater than ever won on field of battle; but even in victory there may be defeat and disaster. Disaster will not come from the acts of any of those truly great leaders, who as a last resort invaded territory never before claimed by surgeon's knife, and with no thoughts of self-aggrandizement, but a simple desire to do good, saved a human life.

##### SPECIALISM.

*Cleveland Medical Gazette.*

SPECIALISM itself, even when liberally defined, is to some extent objectionable; it is accepted in large communities, where alone it is practicable, because of certain counter-balancing advantages. Certainly that spirit of rigid specialism, which would set up the recto-vaginal septum, for example, as a barrier not to be crossed by either the gynecologist or the rectal surgeon can in nowise be defended. Indeed, it is doubtful if so extreme a view, however it may tickle the laity, is held by any member of the medical profession; nevertheless, it is edifying to have the necessity of the overlapping of specialties.

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"THE INCREASE IN QUANTITY & QUALITY  
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Glycerine	- - -	3ii
Acid carbolic	- - -	git. xii. Misce.

Sig.—Use it with absorbent cotton on any wound that you can get at and it makes the cleanest, most soothing and the most effective cicatrisant I ever used, and I have had a great deal of railroad surgery and in the army and mining camps. I think it far superior to Listerine or any antiseptic known. You get the antiseptic effect from the Pond's Extract and Carbolic Acid and the affinity glycerine has for water relieves all inflammation, suppuration and pain. After saturating absorbent cotton with the mixture and carefully applying to the wound you exclude the air entirely and almost hermetically seal the wound. Get some of your medical friends to try this. Pond's Extract is very good in second stage of gonorrhea as an injection.

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# MARYLAND

# MEDICAL JOURNAL

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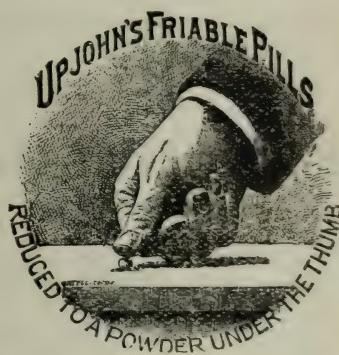
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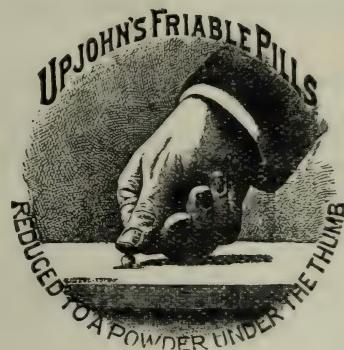
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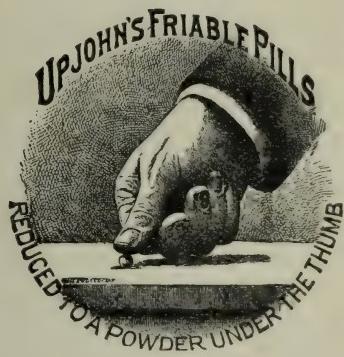
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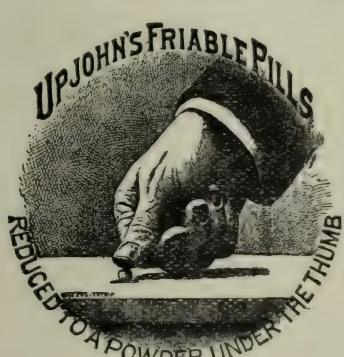
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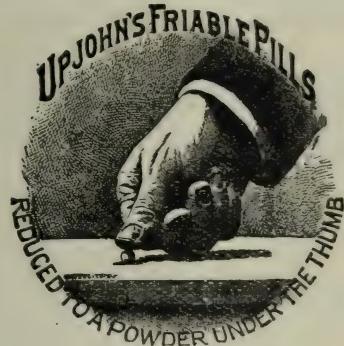
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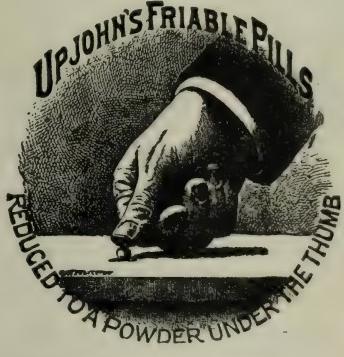
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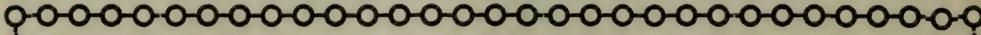
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# MARYLAND MEDICAL JOURNAL

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*AF SCHULZ BAUER*

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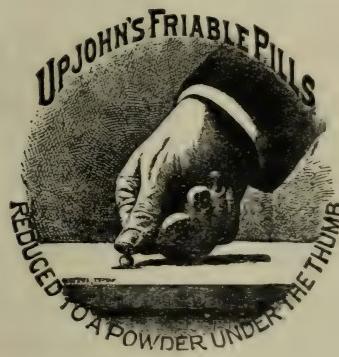
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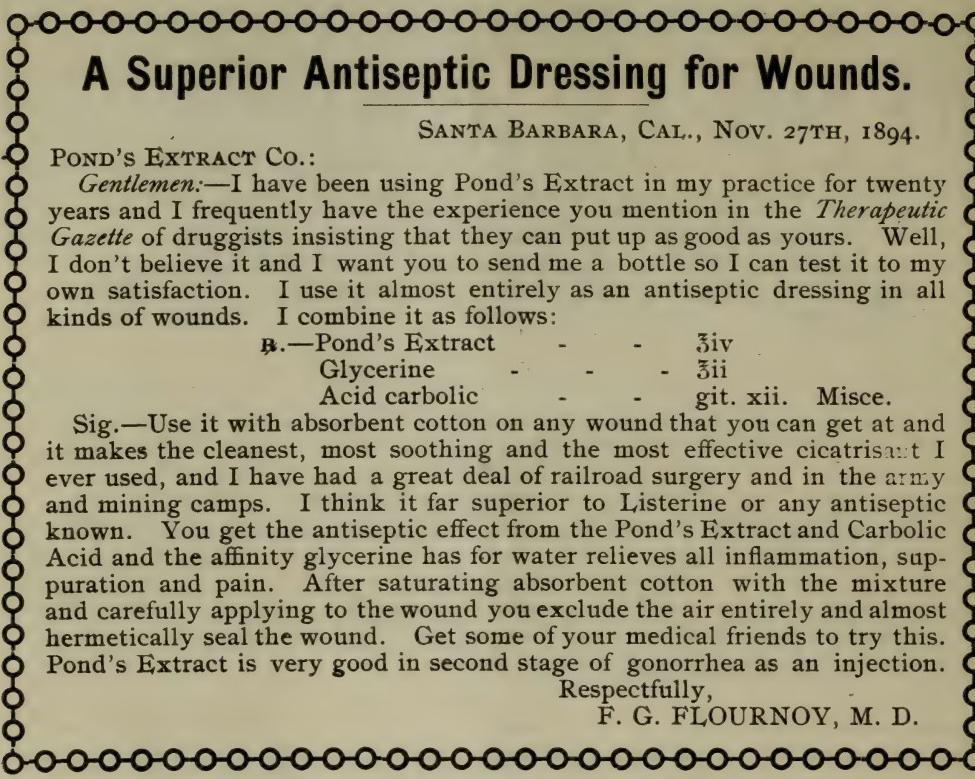
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